88-1520

No.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Petitioner,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

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QUESTIONS PRESENTED

1. Whether, as suggested by the decision below, a state may create a privately-funded and controlled legal entity that has no right to assert a claim of confiscation under the fifth and fourteenth amendments of the United States Constitution.

2. Whether a state may compel an insurer to provide insurance coverage for the benefit of a particular group of policyholders at rates that will require the insurer to operate at a deficit for at least fifteen years.

PARTIES TO THE PROCEEDING BELOW

On the appeal to the Court of Appeals of the State of New York, the respondent, Superintendent of Insurance of the State of New York, was the respondent-appellant. The petitioner, Medical Malpractice Insurance Association, was petitioner-respondent.

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SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

Petitioner, Medical Malpractice Insurance Association ("MMIA"), respectfully requests that a writ of certiorari issue to review the judgment of the Court of Appeals of the State of New York, issued and entered on December 15, 1988, reversing an order of the Supreme Court of the State of New York, Appellate Division, First Department, which had affirmed a judgment of the trial court.

OPINIONS BELOW

The opinion of the Court of Appeals of the State of New York (App. A)[1] is reported at 72 N.Y.2d 753, 533 N.E.2d 1030,

1 Parenthetical references to "App." refer to the Appendices to this Petition. Parenthetical references to "A." and "SA." refer to pages of the Appendix and Supplemental Appendix of the respondent in the proceedings below. Parenthetical references to "RA." refer to pages of the Appendix of MMIA in the proceedings below.

537 N.Y.S.2d 1. The opinions of the Supreme Court of the State of New York, Appellate Division, First Department, are reported at 143 A.D.2d 551, 532 N.Y.S.2d 491 (App. B) and 141 A.D.2d 475, 531 N.Y.S.2d 503 (App. C). The opinion of the Supreme Court of the State of New York, County of New York (App. D), is reported at 137 Misc. 2d 785, 520 N.Y.S.2d 501.

JURISDICTION

The judgment of the Court of Appeals of the State of New York was issued and entered on December 15, 1988. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

MMIA contends that section 40 of chapter 266 of the 1986 Laws of New York ("section 40"), which was implemented by respondent in the Tenth Amendment to Regulation 101, N.Y. Comp. Codes R. & Regs. tit. 11, § 70.8 (1987), violates the fifth and fourteenth amendments to the United States Constitution, U.S. Const. amends. V and XIV, § 1.

STATEMENT OF THE CASE

The Parties

MMIA is a non-profit, unincorporated joint underwriting association ("JUA"), N.Y. Ins. Law § 5502 (McKinney 1985 & Supp. 1989),[2] established by the New York State Legislature in 1975 to provide a market for medical malpractice insurance (A. 1028-29). All insurance companies directly writing personal injury liability insurance in New York are required to be members of MMIA. N.Y. Ins. Law § 5502(a) (McKinney 1985).

2 While MMIA is an unincorporated association, it is also a "legal entity separate and distinct from its members." N.Y. Ins. Law § 5502(b) (McKinney 1985). MMIA in this proceeding therefore asserts constitutional rights on behalf of itself and its members.

Presently, MMIA comprises approximately 350 member insurers domiciled in over twenty-five states.

MMIA is neither an agency nor a branch of the State Government and does not receive funding from the State Treasury. Member companies may be assessed for certain operating expenses, including deficits arising from operations. N.Y. Ins. Law §§ 5503(b), 5507(b) (McKinney 1985). MMIA is governed by a board of fifteen directors: eight elected by the member companies; six appointed by the Superintendent as representatives of physicians, hospitals and the public; and the Superintendent as a non-voting director. N.Y. Ins. Law § 5508(a) (McKinney 1985).

MMIA is required to provide separate policies of primary and excess professional liability insurance up to an annual aggregate of $9 million, upon application of any physician or surgeon licensed in New York. N.Y. Ins. Law §§ 5502(e), 5506 (McKinney 1985 & Supp. 1989); N.Y. Comp. Codes R. & Regs. tit. 11, § 70.9(c)(1) (1988) (Twelfth Amendment). MMIA's ability to meet loss and expense obligations incurred under the policies is contingent upon collection during each year of sufficient premium income derived from actuarially sound rates. In the event that premium income is inadequate to offset loss and expense obligations, the member companies are subject to assessment, without limitation, for the resulting operating deficits. N.Y. Ins. Law § 5507(b) (McKinney 1985). MMIA and its members also may be assessed by New York's Property/Casualty Insurance Security Fund ("Security Fund") when the Security Fund's net assets fall below $150 million as a result of paying claims on behalf of insolvent insurers, including other New York medical malpractice insurers. N.Y. Ins. Law § 7603(a), (c) (McKinney 1985 & Supp. 1989).

Respondent, the Superintendent of Insurance of the State of New York ("the Superintendent"), is the head of the Insurance Department of the State of New York ("the Department"). N.Y. Ins. Law § 201 (McKinney 1985).

Prior to the policy year commencing July 1, 1985, rates for all medical malpractice insurers in New York, including

MMIA, were filed by the insurers with the Superintendent and were subject to his approval. *See* N.Y. Ins. Law § 2305(b) (McKinney 1985). The Superintendent has never approved an adequate rate in any year since MMIA's inception (RA. 12).[3] As a result, New York's major writers of medical malpractice insurance had incurred a combined deficit, as of December 31, 1985, of $1.5 billion (A. 1004-05, 1024, 1267).[4] MMIA's share of this deficit was $80-$85 million (A. 1005).[5] *See also Alliance of Am. Insurers v. Cuomo*, 854 F.2d 591, 594 (2d Cir. 1988).

The combined $1.5 billion deficit, as of December 31, 1985, was already over six times the total amount of money available

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3 As the Superintendent stated in his statutorily-mandated Report to the Governor and the Legislature:

> Every year on the chart [1959 through 1976] shows huge premium deficiencies. For each policy year, premium funds and investment income ran out from 6 to 10 years later. Further, the insurers should have collected about 30% to 200% more in premium each year to adequately pay for the losses they incurred.
>
> . . . .
>
> . . .[I]t is clear (with hindsight) that substantial rate deficiency has been the rule, at least from 1959 through 1979. The accident years since 1979 have been exhibiting a similar pattern of rate deficiency.

N.Y. Ins. Dep't, *A Balanced Prescription For Change: Report of the New York State Insurance Department on Medical Malpractice* 73-74 (1988) ("Department's Report").

4 The principal writer of medical malpractice insurance in New York is the Medical Liability Mutual Insurance Company ("MLMIC"). MLMIC has not sought judicial relief from the Superintendent's inadequate rate determinations because it is owned and operated by insured physicians. In the event it becomes insolvent as a result of inadequate rates, MLMIC's policyholder members will be protected by the Security Fund and will not be assessed any additional premiums (*see* RA. 78-85). MLMIC's rate filings have been found to be improperly influenced by business decisions and other non-actuarial factors (A. 596).

5 This deficit exists even after transfer and utilization of all stabilization reserve fund ("SRF") charges collected by MMIA pursuant to the Insurance Law, *see* N.Y. Ins. Law § 5509 (McKinney 1985 & Supp. 1989). The Department expressly acquiesced in MMIA's use of the SRF charges to reduce its operating deficit. *See MMIA v. Cuomo*, 138 A.D.2d 177, 181, 531 N.Y.S.2d 231, 232 (1st Dep't), *leave to appeal granted*, 143 A.D.2d 548, _____ N.Y.S.2d _____ (1st Dep't 1988).

from the Security Fund. *See* N.Y. Ins. Law § 7603 (McKinney 1985 & Supp. 1989). The annual interest charge on this deficit alone exceeds the maximum annual assessment that could be levied on insurers in New York under the applicable Security Fund statute (A. 1266-68). *See* N.Y. Ins. Law § 7603(b), (c) (McKinney 1985).

Recognizing the magnitude of these deficits and the continuing losses being incurred by MMIA and other medical malpractice insurers, the New York Legislature, effective July 1, 1985, suspended the Superintendent's authority to seek the rehabilitation or liquidation of any New York medical malpractice insurer because of insolvency. 1985 N.Y. Laws ch. 294, § 16, *as amended by* 1986 N.Y. Laws ch. 266, § 8, *as amended by* 1988 N.Y. Laws ch. 184, § 7 (codified at N.Y. Ins. Law § 2343(c) (McKinney Supp. 1989)).

Notwithstanding MMIA's substantial existing deficit as of December 31, 1985, the Department disapproved MMIA's filing for adequate rates for both primary and excess policies for the 1985-86 policy year. In response, MMIA sought and obtained an administrative hearing on the rate disapproval before retired New York Court of Appeals Judge Matthew J. Jasen, who sat as a Special Deputy Superintendent. After a six-day evidentiary hearing, Judge Jasen found that MMIA was entitled to an 86.7% rate increase for the 1985-86 policy year (A. 595).

However, before Judge Jasen's findings could be implemented, the Legislature in July, 1986 enacted chapter 266 of the 1986 Laws of New York ("the 1986 Act"), which, *inter alia*, directed the Superintendent to set physicians and surgeons professional liability rates, retroactive to July 1, 1985, for each policy year 1985-86, 1986-87 and 1987-88. An announced purpose of the enactment was to "restrain" rate increases required by the insurers. 1986 N.Y. Laws ch. 266, § 1. The 1986 Act also authorized future Superintendents, commencing July 1, 1989, to impose an annual surcharge of up to 8% of "an approved adequate rate" in order "to satisfy any actuarially projected deficiency that is attributable to the premium levels estab-

lished'' in each of the 1985-88 policy years. 1986 N.Y. Laws ch. 266, § 40.[6]

The 1986 Act and related legislation included certain changes in the substantive and procedural rules affecting medical malpractice lawsuits in the State.[7] The changes, together with the restraint on premiums, were intended to deal with the ''rising cost of health care'' in the State. 1986 N.Y. Laws ch. 266, § 1.[8] It is generally agreed that the effect of such tort law changes on medical malpractice insurance costs are uncertain and unquantifiable. *See* N.Y. Ins. Dep't, *A Balanced Prescription For Change: Report of the New York State Insurance Department on Medical Malpractice* 79-86 (1988) (''Department's Report'').

Similar tort law changes in several states have been found to have little effect on insurance costs. *See* U.S. Gen. Accounting Office, Report to Congressional Requesters, Pub. No. GAO/HRD-87-21, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (1986). Additional studies also show that ''tort reforms'' have not had their intended effect on insurance costs. *See* Sloan, *State Responses to the Malpractice Insurance ''Crisis'' of the 1970s:*

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6 Section 40 of the 1986 Act was subsequently amended, *inter alia*, to extend the Superintendent's rate-setting authority to policy years 1988-89, 1989-90 and 1990-91 and increase the maximum assessable surcharge to 25% commencing July 1, 1991. 1988 N.Y. Laws chs. 184, § 19 & 186, § 1 (''the 1988 Act'').

7 The changes enacted in 1986 included: certification of the merit of malpractice complaints, reduction in joint and several liability, revision of the appellate review standard, voluntary arbitration and mandatory claims-made policies for new insureds. 1986 N.Y. Laws chs. 266, 682. These changes were in addition to tort law changes enacted in 1985, which included: periodic payment of judgments, limitations on contingency fees, reduction of awards for future collateral source payments, penalties for frivolous claims and defenses, and various changes to speed up pre-trial and trial procedures. 1985 N.Y. Laws ch. 294.

8 Medical malpractice premiums reportedly make up less than 1% of total health care costs. *See* U.S. Gen. Accounting Office, Report to Congressional Requesters, Pub. No. GAO/HRD-86-112, *Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals* 25 (1986).

An Empirical Assessment, 9 J. Health Pol., Pol'y & L. 629, 643 (1985).

Pursuant to provisions of the 1986 Act, the Superintendent—without conducting any hearings in which MMIA or its member companies could participate—established rates for the 1985-86, 1986-87 and 1987-88 policy years (App. G). Despite Judge Jasen's finding of a need for an 86.7% increase for the year commencing July 1, 1985, the Superintendent increased the rates for that year by only 14%, with subsequent increases of only 9% for each of the 1986-87 and 1987-88 policy years.

MMIA commenced a proceeding in the Supreme Court, County of New York ("trial court"), challenging the Superintendent's determination on the grounds, *inter alia*, that it was made in violation of lawful procedure and in violation of the fifth and fourteenth amendments of the United States Constitution.

Judgment of the Trial Court

The trial court referred the proceeding to a referee for a hearing (A. 107-09). At the hearing, the Superintendent did not dispute MMIA's contention that the rates that he had established for policy years 1985-86, 1986-87 and 1987-88 were, in themselves, grossly inadequate (A. 979; *see also* A. 203-04). In fact, the Superintendent's chief actuary testified that the rates for these years likely would impose huge additional deficits on New York medical malpractice insurers (A. 1197-98, 1221-22). The amount of the additional deficits would total at least $1.6 billion (A. 1197-98, 1221-22, 1283, 1287; *see also* A. 314, 961). This deficit amount was on top of the existing combined MMIA/MLMIC deficit, as of December 31, 1985, of $1.5 billion (A. 1004-05, 1024, 1267; *see also* A. 1084-85; RA. 12-13).

The only evidence offered by the Superintendent in support of his rate determinations consisted of what his witness termed "scenario" projections performed by two Department actuaries in response to hypothetical questions (A. 985-86, 988, 1230-

31).[9] The "scenario" projections suggested that the $1.6 billion additional deficit could be recouped through indeterminable future premium surcharges authorized by the 1986 Act. The Superintendent's chief actuary testified that—even assuming the most optimistic of his assumptions, including collection in future years of the largest surcharge legally permissible—the additional deficits likely would not be cured before the year 2000 (A. 314, 1124). This is a period of more than fifteen years from the effective date of the initial deficit rates set by the Superintendent.

With respect to the 1986 legislative tort law changes, the Superintendent's actuary projected only a 5% to 6% reductive effect on the required rate level, thereby reducing Judge Jasen's recommended 86.7% increase for policy year 1985-86 to 76% (RA. 88). However, the Superintendent reduced the amount of the increase to only 14% instead of 76% (App. G). Previously, the actuaries had determined that the 1985 tort law changes would reduce the 1984-85 policy year rate level by only 6%, but the Superintendent had implemented a 15% reduction instead (A. 78, 324).

The Superintendent's actuary testified further that he had advised the Superintendent that the future surcharges would cure the deficits by the year 2000 only "if an otherwise adequate rate were charged commencing policy year 1988." (RA. 4). He had reported to the Superintendent that, based on his projections, the minimum rate level increase required for the policy year 1988 would be 135% (A. 314, 318, 987-88, 1125-26, 1132). Thereafter, rates would have to be maintained at an adequate level in each year in order for MMIA's deficit to be cured within the projected fifteen-year period (RA. 4).[10]

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9 The Department's principal actuarial witness emphasized that the "scenario" projections did not constitute actuarial analysis (A. 985-86, 1231; RA. 16).

10 The subsequent enactment of the 1988 Act, *see supra* p. 6, note 6, made clear that rates commencing policy year 1988, in fact, would

Other unrealistic assumptions included in the actuary's projections were that the number of doctors insured in future years would remain relatively constant, in spite of required large rate increases plus the surcharges on premiums (A. 1023-24, 1038-39, 1059-66, 1067-70),[11] and that the surcharges in fact will be imposed on, and collected from, future generations of physicians who have derived no benefit from the former inadequate rates. The Department's principal actuary admitted that his "scenario" projections required "looking for appropriate rates for policy years 15 years into the future,-and making extrapolations into a very uncertain area based on what we know." (A. 990).

Although finding that the rates established by the Superintendent were inadequate when considered without the future surcharges, the referee recommended that the determination of the Superintendent as to primary rates be upheld, stating that he found no unconstitutionality in requiring MMIA's members to provide a "less desirable . . . kind of service that the Legislature determines is needed, as a condition of doing the more desirable kind of business in the state." (A. 210). After extensive scrutiny of the record, the trial court rejected this recommendation of the referee.

The trial court distinguished a state's power to require MMIA's members to participate in a JUA as a condition of

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not be brought to adequate levels. 1988 N.Y. Laws chs. 184, 186. Under that legislation's extension of the Superintendent's rate-setting authority, the Superintendent has increased physicians and surgeons rates by only 5%, instead of the minimum 135% envisioned by his actuary's projections. N.Y. Comp. Codes R. & Regs. tit. 11, § 70.9(c)(1)(i) (1988) (Twelfth Amendment).

11 Although the Superintendent in the proceedings below contended that an annual surcharge of 25% on top of a greatly increased premium, effective July 1, 1991, will recoup MMIA's losses for the current years, he has separately reported to the Governor and Legislature that physicians would "go bare," *i.e.*, refuse to purchase malpractice coverage, if currently faced with a premium increase of only 32% (Department's Report at 87). If physicians "go bare" when confronted with greatly increased rates plus a 25% surcharge in 1991, there will be no one to pay the surcharge to make up MMIA's deficit.

their doing business in the state from the power to compel the JUA to do business at a loss for the benefit of others:

> That MMIA was created as a non-profit corporation and that membership in MMIA by the member insurers is a condition of their doing business in this State does not give the State, acting through the Superintendent's rate-making powers, the power to require them to invest in or to maintain a losing business for the benefit of others.

(App. D at 33a). Acknowledging that the Legislature's purpose in enacting the tort law changes was to stabilize malpractice rates for the state's physicians, the trial court nonetheless found that:

> It would be impermissible for the Legislature to effectuate that purpose by requiring that the Superintendent act in such a way as to effectuate an unconstitutional result, which would be the case if the statute were to be read to require rates that did not allow a reasonable rate of return to the petitioner or to its members.

(App. D at 30a). The trial court thereupon entered judgment annulling the Superintendent's rate determinations.

Affirmance by the Appellate Division

On appeal by the Superintendent, the Appellate Division of the New York Supreme Court, First Department, affirmed for the reasons stated by the trial court, with two Justices dissenting (App. C at 17a). The dissent rejected MMIA's argument that the imposition of rates compelling it to operate at a loss violates the fifth and fourteenth amendments of the United States Constitution (App. C at 24a).

The Superintendent moved the Appellate Division for reargument and renewal of his appeal (SA. 16-17). The Appellate Division denied the motion to reargue, granted the motion to renew, and, upon renewal, adhered to the determination made in its prior order (App. B).[12]

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12 The reason for the grant of renewal was that the Legislature's enactment of the 1988 Act occurred one day after the initial decision of the

Reversal by the Court of Appeals —

The New York Court of Appeals reversed the order of the Appellate Division, dismissed MMIA's petition and reinstated the determination of the Superintendent as to both primary and excess rates (App. A).[13] Writing for a unanimous court, Judge Vito J. Titone noted that although the rates set by the Superintendent are inadequate and inconsistent with MMIA's solvency, section 40 authorizes the Superintendent to set present inadequate rates in contemplation of the future surcharges (App. A at 5a, 7a-9a). Judge Titone recognized that the surcharges had not been set, nor could they even be determined, until future years (App. A at 4a-5a). He also acknowledged that the rates "are entirely inadequate" without consideration of the future indeterminable surcharges (App. A at 5a). The decision stated that "MMIA may well be forced to run at a deficit until the surcharges result in recoupment in approximately the year 2000." (App. A at 11a).

The court found the fifteen-year period for recoupment to be "not unreasonable" because MMIA likely would have enough cash to pay claims as they come due through the recoupment period (App. A at 12a). In support of this finding, the court cited the projections of the Superintendent's chief actuary. As

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Appellate Division. The Legislature stated in the 1988 Act that one of the purposes was to "clarify the nature of the authority of the superintendent of insurance to establish rates in view of a judicial decision [by the trial court] that has misconstrued the intent of the legislature." 1988 N.Y. Laws ch. 184, § 1. In spite of this legislative pronouncement, the Appellate Division adhered, upon renewal, to the reasoning of the trial court.

13 In upholding the Superintendent's determination as to excess rates, the Court of Appeals took judicial notice of a Regulatory Impact Statement filed by the Superintendent after the referee had issued his report (App. A). To the extent that the Regulatory Impact Statement does not state the law of New York, but merely findings or conclusions of the Superintendent, the court's taking of judicial notice was inconsistent with this Court's decision in *Ohio Bell Telephone Co. v. Public Utilities Commission*, 301 U.S. 292, 296-303 (1937), especially since MMIA had no opportunity to rebut those findings and conclusions.

noted above, the actuary had testified that his projections involved "looking for appropriate rates for policy years 15 years into the future, and making extrapolations into a very uncertain area based on what we know." (A. 990).

Although the decision below recognized that the computations of the Superintendent's actuary were founded upon "the Superintendent's willingness to permit 'adequate' increases beginning in 1988-89 and the following years" (App. A at 10a), the court did not consider legislation and a regulatory amendment, which became effective July 1, 1988, that put off adequate rates for another three years. Pursuant to the 1988 Act, *see supra* p. 6, note 6, the Superintendent—acting on the Legislature's extension of his rate-setting authority—increased the rates for the policy year commencing July 1, 1988 by only 5%, instead of the 135% assumed to be necessary in the projections of his actuary. The Superintendent has indicated that the rates for each of the policy years 1989-90 and 1990-91 also will be increased by only 5%. *See* N.Y. St. Reg., Aug. 17, 1988, at 23 (Regulatory Impact Statement).

The decision below, without citation to any support in the record, stated that, "If the [tort] reforms have their expected salutary effect, the collection of unnecessarily high premiums will be avoided." (App. A at 12a).

With respect to MMIA's claims under the fifth and fourteenth amendments of the United States Constitution, the court below held as follows:

> Finally, we reject MMIA's claim that section 40 is confiscatory as to it. MMIA was created by the Legislature of the State of New York in order to provide much needed medical malpractice insurance. MMIA is a creature of statute, and all of its rights, obligations and duties have been defined by the Legislature (*see*, Insurance Law art 55). . . .
>
> Thus, as a statutory entity created by the Legislature, the State's broad police power can be implemented to fos-

ter affordable medical malpractice coverage, with the possibility that MMIA will operate under a deficit.

(App. A at 12a-13a).

The court further ruled that, "even if MMIA will operate at a continued loss, such a loss is not confiscatory vis-à-vis MMIA," citing this Court's decision in *Brooks-Scanlon Co. v. Railroad Commission*, 251 U.S. 396 (1920) (App. A at 13a).

Although the constitutional rights of MMIA's members were decided by the referee, the trial court and the Appellate Division (*see* Apps. B, C, D), the New York Court of Appeals declined to consider the rights of MMIA's members because they were not named parties in the proceeding.

REASONS FOR GRANTING THE WRIT

I

In Holding that a State-Created Legal Entity, Privately Funded and Controlled, Has Only the Rights Assigned to It by the State Legislature, so that It Cannot Assert a Claim of Confiscation Under the Fifth and Fourteenth Amendments of the United States Constitution, the Decision of the Court Below Conflicts with Applicable Decisions of this Court

In support of the proposition that MMIA, as "a creature of statute," can be compelled to operate at a deficit in order to provide "affordable medical malpractice coverage" to the State's physicians (App. A at 13a), the New York Court of Appeals cited this Court's decision in *Brooks-Scanlon Co. v. Railroad Commission*, 251 U.S. 396 (1920). However, *Brooks-Scanlon* does not support the holding of the court below. To the contrary, this Court's teaching in that case was that a state-chartered corporation cannot be compelled to carry on even a branch of its business at a loss. *Id.* at 399.

The decision of the New York Court of Appeals relied on the following *dictum* from *Brooks-Scanlon*:

> It is true that if a railroad continues to exercise the power conferred upon it by a charter from a state, the state may require it to fulfil an obligation imposed by the charter, even though fulfilment in that particular may cause a loss.

Id. However, beyond that *dictum*, Justice Holmes, writing for the Court, continued as follows:

> But that special rule is far from throwing any doubt upon a general principle too well established to need further argument here. The plaintiff may be making money from its sawmill and lumber business, but it no more can be compelled to spend that than it can be compelled to spend any other money to maintain a railroad for the benefit of others who do not care to pay for it. If the plaintiff be taken to have granted to the public an interest in the use of the railroad, it may withdraw its grant by discontinuing the use when that use can be kept up only at a loss. The principle is illustrated by the many cases in which the constitutionality of a rate is shown to depend upon whether it yields to the parties concerned a fair return.

Id. (citation omitted).

Unlike a private railroad corporation mentioned in the special rule by the *Brooks-Scanlon* Court, MMIA is not voluntarily choosing to continue doing business under its state charter. To the contrary, MMIA is compelled by statute to continue providing insurance coverage to New York's physicians. It is not free to withdraw from the business. Accordingly, it is clear under the holding of *Brooks-Scanlon* that MMIA cannot be compelled to operate at a loss.

Similarly, the two other decisions of this Court cited by the New York Court of Appeals do not support the proposition that MMIA can be compelled to operate its business at a loss. *Atlantic Coast Line Railroad v. North Carolina Corporation Commission*, 206 U.S. 1 (1907), and *Missouri Pacific Railway v. Kansas ex rel. Taylor*, 216 U.S. 262 (1910), each involved an order of a state agency requiring a railroad company to operate a particular branch line as an incident to its charter to operate

railway service within the state. This Court in both cases was careful to draw a distinction between requiring a state-chartered entity to perform a particular duty, even though unprofitable, as an incident to the continued enjoyment of its charter and requiring the company to operate under confiscatory rates affecting the profitableness of the entire operation.

> This is so [the distinction] because, as the primal duty of a carrier is to furnish adequate facilities to the public, that duty may well be compelled, although by doing so, as an incident, some pecuniary loss from rendering such service may result. It follows, therefore, that the mere incurring of a loss from the performance of such a duty does not, in and of itself, necessarily give rise to the conclusion of unreasonableness, as would be the case where the whole scheme of rates was unreasonable under the doctrine of Smyth v. Ames, 169 U.S. 526, 42 L. ed. 842, 18 Sup. Ct. Rep. 418.

Missouri Pac. Ry., 216 U.S. at 278 (quoting, with approval, *Atlantic Coast Line R.R.*, 206 U.S. at 26).

The *Missouri Pacific* Court noted that the incidental pecuniary loss "is a necessary consequence of the acceptance and continued enjoyment of its corporate rights, those rights not having been surrendered by the corporation . . . ." *Id.* at 279. In the present case, MMIA did not voluntarily accept its charter. Nor has it continued to enjoy any privileges under the charter. Instead, it has been compelled by the State to provide insurance to a particular group of State residents, and it is not free to withdraw from the business. Consequently, MMIA cannot be compelled to operate its business at a loss.

Clearly, the New York Court of Appeals has erroneously departed from the teachings of this Court in the three cases that it has cited in support of its holding. The decision below also conflicts with other applicable decisions of this Court.

This Court long ago in *Smyth v. Ames*, 169 U.S. 466 (1898), established that the fifth and fourteenth amendments of the United States Constitution require that state-prescribed rates

not be confiscatory. Justice Harlan, writing for the Court, stated:

> [I]t cannot be admitted that the power granted [to set rates] may be exerted in derogation of rights secured by the Constitution of the United States, or that the judiciary may not, when its jurisdiction is properly invoked, protect those rights.

Id. at 527.

In *Newton v. Consolidated Gas Co.*, 258 U.S. 165 (1922), this Court held that where the prescribed rate had yielded no fair return for more than a year, and that this condition would almost certainly continue for many months, "the company was clearly entitled to relief." *Id.* at 175.

In *West Ohio Gas Co. v. Public Utilities Commission*, 294 U.S. 79 (1935), the state regulatory agency had taken the position—similar to that of the Superintendent in the present case—that any inadequacies in the established rates would be made up by future increased revenues that would result from a projected increase in the company's volume of business. *Id.* at 82-83. Justice Cardozo, for a unanimous Court, rejected this argument stating:

> Upon the record as it comes to us, this is guesswork, and no more. . . . *Present confiscation is not atoned for by merely holding out the hope of a better life to come.*

Id. at 83 (emphasis added).

In *California State Automobile Association Inter-Insurance Bureau v. Maloney*, 341 U.S. 105 (1951), this Court considered the power of a state to compel automobile insurers to participate in a state-mandated automobile insurance pool that offered insurance to those unable to obtain it in the commercial market. While upholding the state's power to compel participation in the pool in order to serve the public interest, *id.* at 109-10, this Court observed that:

> [T]here are important restrictions on the financial commitments incident to the broadened undertaking. We were

> advised on the argument that the premiums chargeable can be commensurate with the greater risks of the new business. Confiscation is therefore not a factor in the case.

Id. at 108.

In the present case, the premiums chargeable are not commensurate with the risks that MMIA and its members are compelled to assume. The decision below recognized that MMIA likely "will operate at a continued loss" (App. A at 13a) and "may be forced to run at a deficit until . . . the year 2000." (App. A at 11a). Thus, unlike *Maloney*, confiscation is manifest in this case.

The suggestion of the court below that the higher premiums may become unnecessary because of the tort law changes is contradicted by the facts. The Superintendent's own actuaries attributed only a minimal reductive effect to the measures enacted by the Legislature. They would have reduced the necessary 1985-86 rate increase of 86.7% only to 76% (RA. 88). However, the Superintendent reduced the increase to 14%. Previous studies have demonstrated that tort law changes have had little effect on medical malpractice insurance costs. *See* U.S. Gen. Accounting Office, Report to Congressional Requesters, Pub. No. GAO/HRD-87-21, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (1986). Indeed, the Superintendent's report to the Governor and Legislature discussed in some detail the difficulty in quantifying the value of tort law changes (Department's Report 79-86), and noted, significantly, as follows:

> Policies covering medical malpractice are generally nonassessable, so that if there is any overestimation of the savings attributable to tort reforms, the resulting deficiency cannot be directly recouped from the policyholders who were charged an inadequate rate.

Department's Report at 80-81.

This court has made clear that actual experience must be considered when evaluating rate standards. *See West Ohio Gas Co. v. Pub. Utils. Comm'n*, 294 U.S. 79 (1935). The court below

ignored actual experience when it relied on the computations of the Superintendent's actuary in concluding that MMIA's deficit would be made up by the year 2000 (App. A at 10a, 12a). The court failed to consider the fact that a major premise of the actuary's computations had not been fulfilled, *i.e.*, "the Superintendent's willingness to permit 'adequate' increases beginning in 1988-89 and the following years" (App. A at 10a). Pursuant to legislation effective July 1, 1988 (*see supra* p. 6, note 6), the Superintendent set the 1988-89 rate level increase at only 5%, instead of the 135% found necessary in his actuary's computations. Therefore, the available evidence showed that the computations were flawed and could not be relied upon for the proposition that MMIA's deficit will be recouped even by the year 2000.

Writing for the Court in *West Ohio Gas Co.*, Justice Cardozo stated:

> But prophecy, however honest, is generally a poor substitute for experience. "Estimates for tomorrow cannot ignore prices of today." . . . "[E]laborate calculations which are at war with realities are of no avail."

294 U.S. at 82 (citations omitted).

The speculative and unquantifiable nature of the surcharges is inconsistent with the well-settled rule of this Court that compensation for a taking must be certain, *Cherokee Nation v. Southern Kansas Ry.*, 135 U.S. 641, 659 (1890), and is due at the time of the taking, *United States v. Dow*, 357 U.S. 17, 20-21 (1958). As the court below recognized, the amount of the future premium surcharges have not been set nor can they even be calculated. Although the surcharge is to be applied to "approved adequate rates" in the future, those future rates themselves cannot be determined until later years.

There is no assurance that the surcharge will be implemented by future Superintendents, if at all, at the levels and for the duration now claimed to be necessary to fund the state-imposed deficits. If implemented, the surcharge may be subject to legal challenges by policyholders who object to subsidizing past poli-

cyholders. Moreover, when faced with a surcharge, policyholders may choose to forego insurance, insure in alternative markets or leave the state. MMIA cannot constitutionally be forced to assume the full burden of the loss and expense obligations incurred under policies issued during each of the 1985-88 policy years in the hope that future generations of policyholders, if any, will be willing and able to pay future surcharges, particularly where many of the future policyholders will have received no benefits under the earlier policies. Without ratepayers, MMIA's deficit will not be recovered.

The court below carved out an exception to the due process and "taking" clauses of the fifth and fourteenth amendments. According to the decision, a state-created entity can be precluded from a claim of confiscation on the ground that it is "a creature of statute, and all its rights, obligations and duties have been defined by the Legislature" (App. A at 13a). The applicable decisions of this Court do not permit such an exception. This Court has made clear that state-prescribed rates cannot be confiscatory. Since the decision below has upheld confiscatory rates, review by this Court is required by writ of certiorari to the New York Court of Appeals.

II

The Decision of the New York Court of Appeals Holding that an Insurer May Be Compelled To Operate at a Loss Under the Fifth and Fourteenth Amendments of the United States Constitution Conflicts with Decisions of Other State Courts of Last Resort

On facts similar to those before the Court on this petition, the Supreme Court of North Carolina rejected, as inconsistent with the fourteenth amendment, a statutory scheme that would have compelled all liability insurers doing business in North Carolina to be members of a non-profit, unincorporated legal entity designated the North Carolina Health Care Liability Reinsurance Exchange ("the Exchange"). *Hartford Accident & Indemn. Co. v. Ingram*, 290 N.C. 457, 226 S.E.2d 498 (1976).

The statutory scheme in *Hartford Accident* required the insurers to provide medical malpractice coverage to any applicant, with the right to shift 100% of the risk assumed to the Exchange. *Id.* at 462-65, 226 S.E.2d at 502-03.

Although noting that North Carolina had a strong public policy obligation to ensure the availability of medical malpractice insurance, the state's highest court declared that "it does not necessarily follow that the State has power to conscript certain persons or corporations, or a certain group thereof, and require such draftees to supply the need at their risk or expense."[14] *Id.* at 467, 226 S.E.2d at 505. Although the statutory scheme called for the establishment of "adequate" and "reasonable" rates, the court held that the scheme was nonetheless unconstitutional, in that the member insurers of the Exchange would still bear an undesired risk of loss:

> The losses and expenses "anticipated" by the Commissioner in the establishment of premium rates may easily prove substantially less than those actually incurred. The record shows, with disturbing clarity, that this has been the experience in the past . . . .

Id. at 469, 226 S.E.2d at 506.

Similarly, the court rejected an argument that because the insurers could cede 100% of every risk to the Exchange, the statute was not constitutionally suspect. *Id.* at 468, 226 S.E.2d at 506. The court noted that North Carolina's statute provided that in the event of losses to the Exchange, its member insurers

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14 In support of this proposition, the North Carolina court cited with approval this Court's decision in *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393 (1922), in which Justice Holmes stated:

> In general it is not plain that a man's misfortunes or necessities will justify his shifting the damages to his neighbor's shoulders. We are in danger of forgetting that a strong public desire to improve the public condition is not enough to warrant achieving the desire by a shorter cut than the constitutional way of paying for the change.

Id. at 416 (citation omitted).

were assessable to the extent of such losses. *Id.* Thus, the court found that while the risks underwritten could be shifted to the Exchange, an undesired risk of loss nonetheless unconstitutionally remained with the member insurers. *Id.* at 468-69, 226 S.E.2d at 506.

Like the liability insurers in *Hartford Accident*, MMIA's members are involuntarily compelled to participate in a state-created JUA and are ultimately responsible for losses resulting from the establishment of inadequate rates chargeable by the JUA. Furthermore, the record shows "with disturbing clarity" that the rates established by the Superintendent have been historically inadequate (RA. 12; Department's Report at 73-74). The rates challenged by MMIA in the proceedings below are admittedly inadequate, absent consideration of indeterminable future surcharges. Clearly, MMIA's member companies are subject to risk of substantial loss, which the Supreme Court of North Carolina held to be constitutionally impermissible. The decision of the New York Court of Appeals obviously is in conflict with the decision of the Supreme Court of North Carolina.

Other decisions upholding state statutes compelling insurer participation in joint underwriting associations uniformly require that the rates chargeable by the JUA be adequate, reasonable and not confiscatory. *See Insurers' Action Council, Inc. v. Markman*, 490 F. Supp. 921, 930 (D. Minn. 1980) (each involuntary insurer is authorized to "apply its own underwriting standards and charge a premium commensurate with the risk assumed" (citation omitted)), *aff'd*, 653 F.2d 344 (8th Cir. 1981); *State Farm Mut. Automobile Ins. Co. v. Whaland*, 121 N.H. 400, 406, 430 A.2d 174, 178-79 (1981) ("Rates are based upon actual loss experience . . . [and the insurer] is free to seek additional or increased rates, providing they are based on tangible factors that justify the levy of a higher premium."); *Sheeran v. Nationwide Mut. Ins. Co.*, 80 N.J. 548, 560, 404 A.2d 625, 631 (1979) ("[i]nability to obtain reasonable rates would, of course, justify judicial correction"). The decision of the New York Court of Appeals rejecting MMIA's claim of confiscation because MMIA is only "a creature of statute" (App. A at 13a)

manifestly conflicts with the federal constitutional restraints enforced by other state courts with respect to JUA rates.

In *Aetna Casualty & Surety Co. v. Commissioner of Insurance*, 358 Mass. 272, 263 N.E.2d 698 (1970), the Supreme Judicial Court of Massachusetts held that insurance rates that would produce an underwriting loss in a single year were confiscatory and unconstitutional:

> While it is not constitutionally required to fix rates which will guarantee a profit to all insurers, it may not constitutionally fix rates which are so low that if insurers engage in business they may do so only at a loss. The insurers are not required to either submit to confiscatory rates or go out of business. They have a right to rates which are not confiscatory . . . .

Id. at 281, 263 N.E.2d at 703.

The decision of the New York Court of Appeals upholding a scheme of inadequate rates—which has been demonstrated to result in losses to the insurer—is clearly in conflict with the decisions of courts of other states. Review by this Court to resolve the conflict among the state courts is required.

III

The Decision of the New York Court of Appeals Is Likely To Force Insurers To Divert Resources from Other States To Fund New York's Growing Medical Malpractice Deficits, Exacerbate Insurance Availability Problems and Cause Confusion and Uncertainty in the National Insurance Marketplace

The uncontroverted evidence in the record of the proceedings below indicates that the two major writers of medical malpractice insurance in New York have developed a combined operating deficit of over $3 billion.[15] The amount of the deficit

15 As a consequence of the Superintendent's refusal to approve adequate rates in prior policy years, MMIA and MLMIC, as of December

continues to accumulate under the inadequate rates that the Superintendent has established for policy year 1988-89. It will grow even larger under the rates that the Superintendent has indicated that he will establish for policy years 1989-90 and 1990-91. Just the interest on this deficit far exceeds the maximum annual assessment available under New York's Security Fund (A. 1266-68).[16]

MMIA's member companies therefore are exposed to substantial risk of assessment for the deficits accruing not only to MMIA but also to other New York medical malpractice insurers. The companies will be forced to divert capital and surplus committed to other states and other lines of insurance to fund the New York malpractice deficits. The size of the assessments are likely to force the liquidation of more insurance companies.[17] The resulting loss of insurance capacity would exacerbate

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31, 1985, had a combined deficit of $1.5 billion (A. 1004-05, 1024, 1267). The rates set by the Superintendent for policy years 1985-86, 1986-87 and 1987-88 were projected to produce a total additional combined deficit of $1.6 billion (A. 1197-98, 1221-22, 1283, 1287).

16 One projection recently made by the Department shows:

> not only a continuing "insolvency", but also that the malpractice insurers would be expected to run out of cash (assets) between the year 2000 and 2005. At that time there will be no money to pay any claims on past, current, or future incidents and a serious crisis would occur. It further shows that the deficit (negative surplus) would continue to grow so that it would exceed $10,000,000,000 before the year 1995.

Department's Report at 107.

17 Mandatory Security Fund assessments were ordered against MMIA and its members, effective May 15, 1988. N.Y. Ins. Dep't Circular Letter No. 9 (1988); *see Alliance of Am. Insurers v. Cuomo*, 854 F.2d 591, 595 (2d Cir. 1988). There have been in recent years sharp increases in the number of insurance companies placed in liquidation and in assessments against security funds. *See The Cost of Property and Casualty Insolvencies: A Special Report from the National Committee on Insurance Guaranty Funds*, in Nat'l Inst. on Insurer Insolvency, ABA Section of Tort & Ins. Practice, *Reference Handbook on Insurance Company Insolvency* 46 (1986).

problems of insurance availability for important forms of risk, which exist in virtually all states.[18]

The decision of the New York Court of Appeals also has introduced great uncertainty in the insurance marketplace. Many insurers do business in several states. Where required, these insurers participate in state-created JUA's in order to satisfy the conditions of doing business in those states. Prior to the decision of the New York Court of Appeals, the insurers could undertake the business of insurance in a state with the assurance that the state could not unfairly compel it to subsidize artificially-restrained insurance costs for a special class of insureds. No longer can that assumption safely be made. Moreover, since the 1986 Act imposed inadequate rates on MMIA retroactively to July 1, 1985, insurers may even be subject to unlimited liabilities through mandated participation in JUA's in states where their resources are already committed.

The scheme of rates upheld by the New York Court of Appeals likely will be adopted by other states to provide coverage for particular classes of risk where insurance otherwise is unavailable or unaffordable. States thereby may benefit their local citizens at the expense of insurance availability on a nationwide basis.

The decision of the New York Court of Appeals also upheld a statutory scheme of "cash-flow" underwriting, which generally has not been permissible under state insurance laws. Cash-flow underwriting greatly increases the risk of insurer insolvencies. Insurance companies can operate on a sound basis only where liabilities are offset by current assets.

> The only way the insurance business can be conducted soundly on an advance premium basis is by providing for the obligations contracted to be met in the future. As we

18 *See* State of N.Y., Governor's Advisory Comm'n on Liab. Ins., *Insuring Our Future* 23-24 (1986). Examples of the most frequently cited "uninsurable" risks include pollution-producing activities, recreational activities, some forms of mass transportation, activities of directors and officers, and child care centers. *Id.*

> have seen, this is done by setting up the present value of these obligations as liabilities. . . .
>
> . . . .
>
> The critical importance of the reserves in the financial stability and solvency of a company is apparent when we recognize that the reserves are true liabilities. Although it is common to think of a reserve as a fund set aside to meet expected or unexpected contingencies, as we have already seen, the reserves we speak of in insurance are true liabilities. They are a true actuarial measurement of the company's liabilities to its policyholders and claimants that must be offset by assets.

E. Vaughan & C. Elliott, *Fundamentals of Risk and Insurance* 141 (2d ed. 1978).

The decision of the New York Court of Appeals condoned a financially disastrous regulatory scheme with broad ramifications for the nationwide liability insurance market. Removing state-created, but privately funded, insurance entities like MMIA from the protections of the fifth and fourteenth amendments will have a disruptive effect on the entire casualty insurance industry. Review by this Court is necessary and warranted.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

Opinion and Judgment of the Court of Appeals of the State of New York

STATE OF NEW YORK
COURT OF APPEALS

Argued November 16, 1988 Decided December 15, 1988

IN THE MATTER OF MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Respondent,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Appellant.

Robert Abrams, Attorney General (Richard G. Liskov, O. Peter Sherwood, Lawrence S. Kahn of counsel), for appellant.

T. Richard Kennedy, Larry P. Schiffer, Michael A. Knoerzer, for respondent.

OPINION OF THE COURT

TITONE, J.

In response to the continuing upward spiral of medical malpractice liability insurance, the Legislature, in 1985 and again in 1986, passed substantive and procedural rules designed to

restrain increases in medical and dental malpractice premiums (*see*, L 1985, ch 294; L 1986, ch 266). The underlying legislative concern was that increasing malpractice premiums threaten the public health by discouraging physicians from initiating or continuing the practice of medicine in New York. The legislative reforms have been challenged on many fronts (*see, Medical Malpractice Ins. Assn. v Cuomo*, 138 AD2d 177, *lv granted* 143 AD2d 548; *Alliance of Am. Insurers v Cuomo*, 854 F2d 591). This article 78 proceeding involves one discrete aspect of the Medical Malpractice Reform Act of 1986 (L 1986, ch 266).

Specifically, petitioner challenges the premium rates set by the respondent, Superintendent of Insurance, pursuant to section 40 of the temporary insurance rate-stabilization program (L 1986, ch 266, § 40). The issue presented is whether the primary and excess premium rates established by the Superintendent pursuant to section 40 are inconsistent with other statutory requirements (*see*, Insurance Law §§ 5505, 2303) and thus arbitrary and capricious. We hold that the Superintendent's interpretation of section 40 was reasonable, that the rates set in reliance on this interpretation were not arbitrary or capricious, and that petitioner's alleged claim of confiscation does not lie. Accordingly, we reverse the order of the Appellate Division which affirmed the Supreme Court judgment annulling the Superintendent's determination, and reinstate that determination.

I.

Petitioner, the Medical Malpractice Insurance Association (MMIA), is a nonprofit unincorporated association which was created by the Legislature in 1975 in response to the withdrawal of many private insurance companies from the medical malpractice market in New York. MMIA was created for the express purpose of providing medical malpractice insurance, which is no longer readily available in the voluntary market (L 1975, ch 109, § 17; *see*, Insurance Law § 5502[c], [d]. MMIA is required to provide primary medical malpractice

insurance to physician applicants with policy limits of $1 million per claim, and an annual aggregate limit of $3 million (Insurance Law § 5502 [e] [1]). In 1985, the Legislature mandated that MMIA provide excess coverage of at least $1 million per claim, and $3 million for all claims in any one policy year (L 1985, ch 294, § 17). Since 1975, the Superintendent has set premium rates pursuant to provisions of the Insurance Law requiring the lowest possible rates consistent with the maintenance of MMIA's solvency, and the establishment of reasonable reserves and surpluses (Insurance Law § 5505 [a], [b]; *see also*, Insurance Law § 2303).

From 1980 to 1985, MMIA's rate increased by over 200%. To alleviate this critical problem, in 1985 and 1986, the Legislature implemented various changes in the prosecution of medical malpractice liability cases (L 1985, ch 294; L 1986, chs 266, 682). Significant changes were made in payment of damages, attorneys' fees, pretrial discovery, and the application of joint and several liability for noneconomic losses (*see generally*, Note, *New York's Medical Malpractice Insurance Crises—A New Direction for Reform*, 14 Fordham Urban LJ 773[1986]).

A hearing on the rates to be established for 1985-1986 was held before a Special Deputy Superintendent (SDS). Following extensive hearings, the SDS found that MMIA was entitled to an 86.7% increase in physician and surgeon rates. However, before recommendations could be implemented, the Governor signed the Medical Malpractice Reform Act of 1986 (L 1986, ch 266). Pursuant to section 40 of this Act, the Superintendent was directed to establish rates for each policy year commencing July 1, 1985 through June 30, 1988. In addition, section 40 authorized the Superintendent, commencing July 1, 1989, to impose an annual surcharge of up to 8%, if needed, to satisfy any actuarially projected deficiency resulting from the rates that he had established for each of the 1985-1988 policy years (L 1986, ch 266, § 40). Section 40 provides that the surcharges shall be deemed income earned for the purposes of Insurance Law

§ 2303 which requires that premium rates be calculated in such a way as to maintain solvency.[1]

Relying on section 40, the Superintendent promulgated the Sixth, Seventh, Eighth and Tenth Amendments to Regulation No. 101 (11 NYCRR 70.8) establishing primary and excess premium increases for 1985-1986, 1986-1987, and 1987-1988. The allowed increases have been established as follows:[2]

	Primary Rate	Excess Rate	
		1st Layer	2nd Layer
1985-1986	14%	30%	30%
1986-1987	9%	35%	24%
1987-1988	9%	40%	28%

The Superintendent has not yet established a surcharge rate, since, under section 40, such a determination can only be calculated after any deficiency arising from the prior years is deter-

1. Section 40 provides in pertinent part that: "The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-eight. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July first, nineteen hundred eighty-nine, the superintendent shall impose a surcharge on premiums to satisfy any actuarially projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the approved adequate rate and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency * * * The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law" (L 1986, ch 266, § 40).

2. When this action was initiated only the Sixth and Seventh Amendments had been passed, and thus only these amendments were challenged. However, the parties have agreed by stipulation to allow petitioner to supplement its petition and challenge the provisions of the Eighth and Tenth Amendments.

mined. However, in order to facilitate the calculation of deficiencies arising from the three policy periods, and the corresponding future surcharge needed to offset the prior deficiencies, the Superintendent directed the establishment of segregated accounts for premium payments, reserves and investment income attributable to each of the policy periods. Critically, in setting these rates, the Superintendent concededly considered that a surcharge of up to 8% could be imposed in the future. Both parties agree that without this consideration of future surcharges, both the primary and the two excess layers of insurance are entirely inadequate to meet the statutory standards of solvency under the Insurance Law (*see*, Insurance Law §§ 5505, 2303).

MMIA brought the present article 78 proceeding to challenge the Superintendent's approach, contending that his interpretation of section 40 is unreasonable, and has resulted in rates which are not actuarially sound, self-supporting, based upon reasonable standards or consistent with statutory standards of solvency. MMIA also claims that the rates are confiscatory and will result in an unconstitutional taking of property in violation of the State and Federal Constitutions (US Const 5th, 14th Amends; NY Const, art I, §§ 6, 7).

Implementation of the rates was stayed on August 12, 1986, and the parties agreed by stipulations to interim primary and excess rates for the 1985-1988 policy years pending exhaustion of all appeals in this proceeding. The issues raised in the proceeding were then submitted to a Referee, who agreed with the Superintendent that future surcharges should be considered in fixing present rates, and concluded that the Superintendent, in setting the 1985-1988 primary rates, properly relied upon actuarial figures derived, in part, from the original figures supplied by the SDS. However, concerning the excess rates, the Referee recommended a remand to the Superintendent for further explanation since he found the record before him to be insufficient.

Supreme Court rejected the Referee's report and set aside the determination of the Superintendent. The court disagreed with

the Superintendent's interpretation of section 40, reasoning that the language directing insurers to establish segregated accounts for the 1985-1988 policy years expressed a "legislative hope that the rates to be set would be sufficient, under the existing circumstances of general uncertainty in the malpractice insurance field", without any surcharge at all (137 Misc 2d 785, 791). The court ruled that future surcharges were not even to be considered by the Superintendent, "until his monitoring of the accounts toward the end of the 1985-1988 period established a necessity for that action" (*id.*). The Superintendent's interpretation was found to be at odds with the "self-supporting" requirement for rates contained in section 5505 (Insurance Law § 5505). The court also rejected the Referee's findings that the rates established would not impermissibly impair the solvency of MMIA, and questioned the constitutionality of section 40. Finally, the court gave short shrift to the Superintendent's actuarial calculations concerning future rate structure. The court simply classified the figures as "scenarios", and concluded they were insufficient. A divided Appellate Division affirmed on Supreme Court's opinion, the dissenting Justices agreeing with the Superintendent's interpretation of section 40, particularly in view of its provision treating surcharges as earned income for the purposes of section 2303 (*see*, Insurance Law § 2303 [requiring that all earned income be included in determining whether the rates comply with the statutory requirements of solvency]).[3]

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3. Following the Appellate Division's affirmance, section 40 was amended as follows: "Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates" (L 1988, ch 184, § 19).

The amendment was made retroactive to July 8, 1986, the day before the rates challenged in this proceeding were initially promulgated (L 1988, ch

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II.

At issue in this appeal is whether the Superintendent's consideration of future surcharges in the fixing of present rates was consistent with section 40, and the statutory requirements of solvency set forth in sections 2303 and 5505 of the Insurance law. Section 5505 (b) of the Insurance Law, which governs MMIA, provides in pertinent part: "All rates shall be on an actuarially sound basis, be calculated to be self-supporting, be based upon reasonable standards * * * The premiums shall be fixed at the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves and surplus therefor." Section 2303 provides that the "[r]ates shall not be * * * detrimental to the solvency of insurers." As the parties agree, without the consideration of future surcharges in determining present rates, the rates set by the Superintendent would be inadequate and would not satisfy the statutory requirements of solvency.

In reviewing the Superintendent's interpretation of his legislative authorization in section 40, we defer to his special expertise and views, unless the interpretation is irrational or runs counter to the clear wording of the statutory provision (*see, New York Pub. Interest Research Group v Town of Islip*, 71 NY2d 292, 303; *Matter of New York Pub. Interest Research Group v New York State Dept. of Ins.*, 66 NY2d 444, 448;

184, § 22). In addition, other amendments extend the Superintendent's authority to establish rates pursuant to section 40 through June 30, 1991, and increases the maximum surcharge to 25%, beginning in the 1991-1992 policy year, and continuing until any deficiencies have been recouped (L 1988, ch 184, § 19; ch 186).

After these enactments, respondent sought to renew and/or reargue before the Appellate Division. The court granted renewal but adhered to its original decision, the same two Justices again dissenting. By stipulation, both the appeal from the original decision, and the appeal from the order adhering to that decision, have been consolidated. Since we conclude that the Superintendent's original interpretation of the unamended version of section 40 was proper, we need not address the effects, if any, of the subsequent amendments.

Kurcsics v Merchants Mut. Ins. Co., 49 NY2d 451, 459; *Ostrer v Schenck*, 41 NY2d 782, 785). We conclude from the statute and its history that the Superintendent's interpretation of the statute is reasonable and should be sustained.

The Superintendent's position is based upon the last sentence of section 40, which provides: "The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law." He also relies on Insurance Law § 2303, which provides that "[i]n determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer". Construing these provisions together, the Superintendent concluded that the anticipated future surcharges, which are designated as income earned, should be considered both in determining present rates and in calculating the solvency of MMIA as required by sections 2303 and 5505. This view of the statutory language is reasonable. If future surcharges were not to be accounted for until actually received beginning in 1989, then the last sentence of section 40 would be superfluous, since moneys actually received would undoubtedly be deemed income earned at that time. Thus, the Legislature must have intended that the future surcharges be considered on an accrual basis similar to the treatment of investment income (*see generally*, McKinney's Cons Laws of NY, Book 1, Statutes §§ 92, 94).

Further, the legislative history is clear. Governor Cuomo noted in his approval memorandum that "the bill authorizes the Superintendent of Insurance to establish rates for a three-year period (July, 1985-June, 1988) that will provide a measure of badly needed premium stability as these reforms begin to take hold. *In establishing these premium levels, the Superintendent is authorized to consider the availability of surcharges in future years that could be imposed*, beginning in 1989, to restore any potential deficiency created during the premium stabilization period" (1986 NY Legis Ann, at 161 [emphasis added]).

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It is clear that temporary rate stabilization is designed to complement the numerous remedial measures codified in 1985 and 1986 (L 1985, ch 294; L 1986, ch 266). Section 40 is designed to bridge the gap and allow the other reforms to start taking effect. Further, as pointed out by the dissenting Justices, if petitioner's interpretation of section 40 is correct, section 40 would mean nothing and do nothing. If the Superintendent cannot account for future surcharges in calculating present rates, then the current rate increase would have to be approximately 86.7%—the rate recommended by the SDS. Nothing in chapter 266 reveals that the Legislature intended such extraordinary increases in premiums from 1985 through 1988. To the contrary, as chapter 266, section 1, plainly states, the purpose of the chapter is to "reduce the cost of [medical] malpractice insurance * * * [and] significantly reduce physician and health care system costs in the short-run" (L 1986, ch 266, § 1), during which time the positive actuarial effects of the prophylactic measures in the 1985 and 1986 legislation can begin to serve their purpose.

Thus, we conclude that the Superintendent correctly interpreted section 40 by considering future surcharges.

III.

We next consider whether the Superintendent's reliance upon his actuary's calculations was arbitrary or capricious (*see*, CPLR 7803 [3]; *Matter of Colton v Berman*, 21 NY2d 322; *Matter of Schwartz v Corcoran*, 118 AD2d 355, 361). Supreme Court gave short shift to respondent's actuarial data, simply labeling them as "scenarios", and concluding that the rates were not set on an actuarial basis as required by Insurance Law § 5505 (b). However, as the Referee found, actuarial data existed, and the Superintendent's rate decisions were based on such data. It is axiomatic that a court reviewing the determination of an agency may not substitute its judgment for that of the agency and must confine itself to resolving whether the determination was rationally based (*see, Matter of Procaccino v. Stew-*

art, 25 NY2d 301). We conclude that in annulling the Superintendent's determination the courts below exceeded their review powers.

Throughout the course of this litigation, the parties' actuaries have disagreed on almost everything. Just as they disagree concerning the impact of the surcharge on future deficits, the actuaries also disagree about the potential beneficial impact of the 1985 and 1986 reform legislation. A disagreement among actuaries, however, is not evidence that the Superintendent's acceptance of one set of conclusions was arbitrary (*see, Matter of New York State Council of Retail Merchants v Public Serv. Commn.*, 45 NY2d 661, 672-674; *Montgomery v Daniels*, 38 NY2d 41, 53).

Respondent's actuarial projection used the SDS's 86.7% suggested rate increase as a starting point. The purpose of this calculation was to determine whether an 8% surcharge to future premiums, commencing with the policy year 1989-1990, would ultimately offset deficiencies arising from the curtailed rates set for policy years 1985-1988. Based on the Superintendent's calculations, it was shown that the deficit caused by the 1985-1988 rates could be cured by approximately the year 2000. While the computation was founded upon numerous assumptions, including future interest rates, projected decreases in severity of claims due to accompanying legislative reforms,[4] and the Superintendent's willingness to permit "adequate" increases beginning in 1988-1989 and the following years, the use of such

4. Severity refers to the amount of losses on such claims. Importantly, section 5505 (a) provides that MMIA's rates shall give "due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the superintendent may require." (Insurance Law § 5505 [a].) Thus, section 5505 (a) instructs the Superintendent to extrapolate upon trends in medical malpractice insurance. It cannot be deemed unreasonable, as a matter of law, to consider the potential beneficial impact of the accompanying reforms on the severity of future claims.

assumptions does not render the Superintendent's conclusions irrational.

As to the rates for layers of excess coverage, the Referee concluded that the record as to how the rates for excess policies were calculated was not complete, and thus recommended remitting this question to the Superintendent for further explanation. We disagree (*see, Matter of Colton v Berman*, 21 NY2d 322, 334, *supra*).

As he has consistently done in the past, the Superintendent fixed over-all rates for excess layers as percentages of the rates approved for primary coverage. In addition, the Superintendent's actuarial witness testified that while excess programs at inadequate rates would increase the deficit, there would be greater surcharge income in future years, and that the two would offset each other. This alone should have been sufficient (*see, Matter of Procaccino v Stewart*, 25 NY2d 301, *supra*). Moreover, this court can take judicial notice of the Regulatory Impact Statement (*see*, CPLR 4511 [b], [c]) which the Superintendent filed in connection with the Ninth Amendment to Regulation No. 101 while this case was pending before the Supreme Court (*see*, 11 NYCRR 70.8). This statement explains how the same factors used by the actuaries in setting primary rates were also used in setting excess rates, and consequently supplies an adequate rational basis for the excess rates (*see*, New York State Register, May 6, 1987, at 10-11; *see also*, CPLR 7803; *Matter of Colton v Berman*, 21 NY2d 322, *supra*).

IV.

Accepting the Superintendent's interpretation of section 40 and his actuarial projections, it is apparent that MMIA may well be forced to run at a deficit until the surcharges result in recoupment in approximately the year 2000. Petitioner argues that requiring MMIA to run a continued deficit for this length of time proves that the Superintendent's decision is arbitrary and capricious, and, alternatively, results in a confiscation of property in violation of the Fifth and Fourteenth Amendments

of the United States Constitution (US Const 5th, 14th Amends) and article I, sections 6 and 7 of the New York State Constitution (NY Const, art I §§ 6, 7).

According to the express language of section 40, there is no time limit within which the deficits must be made up. Section 40 merely provides that the 8% surcharge "shall continue for such period of time as shall be sufficient to satisfy such deficiency" (L 1986, ch 266, § 40). As previously noted, the deficit attributable to the diminished rates for 1985-1988 on primary and excess policies will be recouped by about the year 2000. This 15-year period for recoupment is not unreasonable, since according to respondent's chief actuary, the established rates coupled with the 8% surcharge after 1989, will enable MMIA to remain liquid and pay claims as they come due, at least through the year 2010. More importantly, medical malpractice claims are "long-tailed", so that claims made on policies written between 1985 to 1988 will not, on average, be payable until after 1995-1998. Thus, it is entirely conceivable that the deficit will be made up while some losses attributable to policies written and premiums collected in 1985-1988 are still unpaid.[5] The combination of the "long-tailed" nature medical malpractice claims along with the other statutory reforms promulgated under the 1985 and 1986 acts makes the long-term deficit entirely reasonable. If the reforms have their expected salutary effect, the collection of unnecessarily high premiums will be avoided. If the reforms are not as successful as expected, the surcharge provides a sensible method of meeting any deficiency that may develop over the long period within which claims mature.

Finally, we reject MMIA's claim that section 40 is confiscatory as to it. MMIA was created by the Legislature of the State of New York in order to provide much needed medical malprac-

5. In its Regulatory Impact Statement, the Superintendent points out that the average payout time for excess claims is significantly greater than 10 years. "Since many excess losses for policies written in policy years 1985/86 and 1986/87 will not be payable until beyond the year 2000, the excess deficit will be made up while some losses attributable to excess policies written during policy years 1985/86 and 1986/87 remain unpaid" (New York State Register, May 6, 1987, at 11).

tice insurance. MMIA is a creature of statute, and all of its rights, obligations and duties have been defined by the Legislature (*see*, Insurance Law art 55). MMIA may operate only for fixed periods of time and only if the Superintendent determines that medical malpractice insurance is not readily available in the voluntary market (Insurance Law § 5505 [d]). In addition, MMIA's operations are subject to the Superintendent's extensive and direct control (Insurance Law § 5503 [c]). Importantly, although all insurance companies writing personal injury insurance in New York are required to be members of MMIA as a condition of transacting business in this State (Insurance Law § 5502 [a]), MMIA is a nonprofit unincorporated association which is a legal entity separate and distinct from its members (Insurance Law § 5502 [b]). Moreover, all funds and reserves of MMIA are held and invested separately from its members (*id.*).

Thus, as a statutory entity created by the Legislature, the State's broad police power can be implemented to foster affordable medical malpractice coverage, with the possibility that MMIA will operate under a deficit. Indeed, such deficits were expressly contemplated in the enabling legislation (Insurance Law § 5507, 5509). In this regard, even if MMIA will operate at a continued loss, such a loss is not confiscatory vis-à-vis MMIA (*see, Brooks-Scanlon Co. v Railroad Commn.*, 251 US 396, 399 ["It is true that if a railroad continues to exercise the power conferred upon it by a charter from a State, the State may require it to fulfil an obligation imposed by the charter, even though fulfilment in that particular may cause a loss."]; *Missouri Pac. Ry. Co. v Kansas*, 216 US 262, 276, 278; *Atlantic Coast Line v North Carolina Corp. Commn.*, 206 US 1). Since the individual insurance companies which are members of MMIA and are required to make up any deficit which may be incurred by MMIA (Insurance Law § 5507 [b])[6] are not parties

6. MMIA, from its very inception, has been required to maintain a stabilization reserve fund for the purpose of offsetting deficits and "for reimbursement to the association's members for payment of any deficit arising out of the operations of the association" (Insurance Law § 5509 [a]). While

to this proceeding, we do not consider the degree to which the Superintendent's regulations, or the underlying statutory scheme, may be confiscatory as to them (*see, Alliance of Am. Insurers v Cuomo*, 854 F2d 591, *supra*).

Accordingly, the order of the Appellate Division should be reversed, with costs, the petition dismissed and the determination of the Superintendent of Insurance reinstated.

Chief Judge WACHTLER and Judges SIMONS, KAYE, ALEXANDER, HANCOCK, JR., and BELLACOSA concur.

Order reversed, etc.

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recent legislation has been passed affecting the stabilization fund (L 1986, ch 266, § 11), MMIA has not raised any claims concerning the stabilization fund in this action (*see, Medical Malpractice Ins. Assn. v Cuomo*, 138 AD2d 177, *lv granted* 143 AD2d 548).

Appendix A

Remittitur

COURT OF APPEALS
STATE OF NEW YORK

The Hon. Sol Wachtler, Chief Judge, Presiding

1 No. 331

In the Matter of Medical Malpractice Insurance Association,
Respondent,

v.

Superintendent of Insurance of the State of New York,
Appellant.

The appellant in the above entitled appeal appeared by Hon. Robert Abrams, Attorney General of the State of New York; *the respondent appeared by* Werner Kennedy & French, Esqs.

The Court, after due deliberation, orders and adjudges that the order is reversed, with costs, petition dismissed and determination of the Superintendent of Insurance reinstated. Opinion by Judge Titone. Chief Judge Wachtler and Judges Simons, Kaye, Alexander, Hancock and Bellacosa concur.

The Court further orders that the papers required to be filed and this record of the proceedings in this Court be remitted to the Supreme Court, New York County *there to be proceeded upon according to law.*

I certify that the preceding contains a correct record of the proceedings in this appeal in the Court of Appeals and that the papers required to be filed are attached.

/s/ DONALD M. SHERAW
Donald M. Sheraw, Clerk of the Court

Court of Appeals, Clerk's Office, Albany, December 15, 1988

APPENDIX B

Memorandum Opinion of the Supreme Court of the State of New York, Appellate Division, First Department

SUPREME COURT OF THE STATE OF NEW YORK,
APPELLATE DIVISION, FIRST DEPARTMENT

Decided September 20, 1988

In the Matter of MEDICAL MALPRACTICE INSURANCE ASSOCIATION v SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK.—Motion (1) granted only insofar as to permit renewal and, upon renewal, this court adheres to the determination in its order [141 AD2d 475], and (2) denied wherein it seeks reargument. Kupferman, J. P., Sullivan and Kassal, JJ., concur; Asch and Rosenberger, JJ., dissent.

APPENDIX C

Memorandum Opinion of the Supreme Court of the State of New York, Appellate Division, First Department

SUPREME COURT OF THE STATE OF NEW YORK,
APPELLATE DIVISION, FIRST DEPARTMENT

Decided June 30, 1988

In the Matter of MEDICAL MALPRACTICE INSURANCE ASSOCIATION, Respondent, v SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK, Appellant.—Judgment, Supreme Court, New York County (Martin Evans, J.), entered on October 21, 1987, affirmed for the reasons stated by Martin Evans, J., without costs and without disbursements. Concur—Kupferman, J. P., Sullivan and Kassal, JJ.

Asch and Rosenberger, JJ., dissent in the following memorandum by Asch, J. In rejecting the determination of the Superintendent of Insurance, the majority rejects the labors of successive Legislatures, two Governors of the State of New York, representatives of the public and the medical profession, all of whom have struggled to fashion a solution for the awesome problem of accelerating medical malpractice insurance costs. The result of their efforts, in my opinion, is a feasible plan to restrain such insurance rates, a plan which is clearly supported by statute and principles of constitutional law. Accordingly, I would reverse the judgment and order which granted petitioner's CPLR article 78 petition and annulled the Superintendent's determination as set forth in Regulation No. 101 (11 NYCRR 70.8) and the amendments thereto.

The Legislature, with former Governor Carey, enacted, in 1975, current article 55 of the Insurance Law, enabling peti-

tioner Medical Malpractice Insurance Association (Association) to act as a nonprofit joint underwriting association of insurers. Under this legislation, the Association is to provide coverage at the lowest possible rates consistent with solvency and reasonable rates and surplus (Insurance Law § 5505).

The rates, however, continued to spiral upward, prompting modification by the Legislature of substantive and procedural rules relating to medical malpractice suits (*see*, L 1985, ch 294; L 1986, ch 266). The Medical Malpractice Reform Act of 1986 (L 1986, ch 266) amended the CPLR, Insurance Law, Public Health Law and other statutes, declaring:

"Section 1. Legislative findings and declaration. The legislature hereby finds and declares that reforms have been enacted to restrain increases in medical and dental malpractice premiums and related costs and to prevent medical and dental malpractice * * *

"In the meantime, the legislature finds and declares that upward pressures on already high malpractice premiums continue to threaten the public health by discouraging physicians and dentists from initiating or continuing their practice in New York and by contributing to the rising cost of health care as premium costs are passed along to health care consumers.

"The legislature finds and declares, therefore, that additional steps must be taken in the public interest to reduce the cost of malpractice insurance, such as providing the superintendent of insurance with the authority to establish rates for medical malpractice insurance and gradually requiring the issuance of only claims-made policies which will significantly reduce physician and health care system costs in the short-run and substantially enhance the reliability and predictability of malpractice insurance rate regulation in the future."

Governor Cuomo, who had participated very vigorously in seeking a solution to the problem, approved the legislation and in strong language endorsed the modus operandi for keeping down malpractice insurance rates. In his approval memorandum (1986 NY Legis Ann, at 161), he said, in part: "The bill focuses, moreover, on the insurance system itself. The previ-

ously enacted reform of the State's regulatory authority over liability insurance is complemented by provisions in this bill that gradually require the transition to 'claims-made' coverage, which will permit significantly lower premiums in the short run as well as greater actuarial certainty and predictability. In addition, the bill authorizes the Superintendent of Insurance to establish rates for a three-year period (July, 1985-June, 1988) that will provide a measure of badly needed premium stability as these reforms begin to take hold. In establishing these premium levels, the Superintendent is authorized to consider the availability of surcharges in future years that could be imposed, beginning in 1989, to restore any potential deficiency created during the premium stabilization period. The bill also continues to provide hospital-affiliated physicians with an additional one million dollars of protection to cover claims in excess of affordable insurance coverage—and provides this coverage in a manner that protects hospitals from a financial burden that they cannot fairly assume."

In an attempt to "significantly reduce physician and health care system costs in the short-run", the avowed purpose of the legislation, section 40 of Laws of 1986 (ch 266) provided: "§ 40. The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-eight. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July first, nineteen hundred eighty-nine, the superintendent shall impose a surcharge on premiums to satisfy an actuarially projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the approved adequate rate

and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency * * * Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law."

In accordance with this legislation and faced with a pending request for a rate increase (and a recommendation by Honorable Matthew J. Jasen as Special Deputy Superintendent-Hearing Officer for, *inter alia*, an 86.7% increase in primary insurance premium rates for 1985-1986 over 1984-1985), the Superintendent promulgated the Sixth Amendment to Regulation No. 101 (11 NYCRR 70.8) establishing primary rates for such insurance of 14% for the 1985-1986 policy year and 9% for the 1986-1987 policy year. The Seventh Amendment additionally established excess rate levels for the 1985-1986 and 1986-1987 policy years.

Although he did not establish a surcharge percentage to be imposed starting in 1988-1989 (since such imposition must await a determination of the deficiency arising in prior years), the Superintendent directed the establishment of segregated accounts for premium reserves and investment income for each of the policy periods, so that deficiencies arising from each period and the amount of surcharges necessary could be ascertained more readily.

The petitioner Association brought this proceeding challenging the rates fixed by the Superintendent in Regulation No. 101. It contended the rates were inadequate and did not meet the statutory standards set in Insurance Law §§ 5505 and 2303 in that, *inter alia*, they are not actuarially sound, are not calculated to be self-supporting or based upon reasonable standards,

are not consistent with the maintenance of reasonable reserves and surplus and, additionally, that the Superintendent's action in fixing the rates for 1985 through 1988 was arbitrary and capricious and without rational basis.

The Supreme Court referred the matter to Honorable Samuel J. Silverman to hear and report on the issues. In a detailed and comprehensive report, Justice Silverman agreed with the respondent that section 40 of Laws of 1986 (ch 266) authorized the consideration of the future surcharges in fixing rates for the July 1, 1985 to June 30, 1988 period. He further found that the primary rates fixed by the Superintendent in reliance upon his actuary's calculations were not arbitrary or capricious or without rational basis. As for the rates for excess policies, he recommended a remand for further explanation by the Superintendent since the record before him was insufficient. The Supreme Court rejected this report and set aside the determination of the Superintendent fixing the rates in Regulation No. 101, directing the Superintendent to fix the 1985-1988 rates in accordance with the Insurance Law. The majority of this court agrees with that judgment. I do not and would reverse, confirming Justice Silverman's report and denying the relief requested in the petition with respect to the primary rates for 1985-1988.

Petitioner, as indeed the nisi prius court, relies mainly on the provisions of the Insurance Law predating the enactment of section 40. Thus, section 5505 of the Insurance Law, which relates specifically to the petitioner, provides in pertinent part:

"§ 5505. Rates

"(a) The rates, rating plans, rating rules, rating classifications, territories and statistics applicable to the insurance written by the association shall be subject to article twenty-three of this chapter, giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the superintendent may require.

Appendix C

"(b) All rates shall be on an actuarially sound basis, be calculated to be self-supporting, be based upon reasonable standards * * * The premiums shall be fixed at the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves and surplus therefor."
Section 2303 of the Insurance Law provides: "§ 2303. Standards for rates. Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers. In determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer and any insurer controlling or controlled by such insurer or under common control by or with such insurer on all its investments of any kind and wherever located."

As the Referee found, the primary insurance rates as fixed by the Superintendent *without* the imposition of any surcharges are inadequate and would not meet the statutory standards set out above.

However, section 40 of Laws of 1986 (ch 266) expressly authorized the Superintendent to set the rates for the 1985-1988 policy years at levels *below* those authorized solely by consideration of the prior statutory criteria *and to make up any ongoing deficit by calculating and including the anticipated surcharges.* Thus, section 40 explicitly provides: "The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law." Section 2303 provides, *inter alia*: "In determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer". Thus, the surcharges were correctly utilized by the Superintendent to determine income when he set the rates for the 1985-1988 period.

Further, section 40 provides that the purpose of the surcharges is to satisfy deficiencies "attributable to the premium levels established pursuant to this section for such periods" (i.e., July 1, 1985 to June 30, 1988). It also provides for allocation of amounts collected on the surcharge among insurers

based on the extent of coverage provided during the 1985-1988 period. These provisions only make sense, as noted by the Referee in his report, if the rates for which the surcharges are considered income are the rates for the period 1985-1988.

Section 5505(b) requires rates set by the Superintendent for petitioner to be self-supporting but also fixed "at the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves and surplus therefor". The inclusion of the surcharge income, which is expressly sanctioned by the Legislature, fulfills this purpose of achieving the lowest possible rates together with insuring that the solvency of the Association is maintained. In this regard, respondent's chief actuary testified that in his opinion, on the basis of the rates established and with the 8% surcharge after 1989, the petitioner will have sufficient cash to meet its obligations as they mature at least through the year 2010, i.e., *beyond* the years at which the deficit for 1985-1988 would have been made up.

With this interpretation, section 40 of Laws of 1986 (ch 266) and sections 2303 and 5505, the preexisting statutes, are harmonized and all of the respective provisions effectuated (*see*, *Matter of Guardian Life Ins. Co. v Chapman*, 302 NY 226, 231). Accepting petitioner's interpretation, section 40 means nothing and does nothing and the plain intent of the Legislature and Governor are disregarded. (*See*, L 1986, ch 266, § 1; Governor's approval mem, *op. cit.*, at 161.)

We have previously noted in another matter involving the Superintendent's implementation of the Insurance Law: "Special Term substituted its judgment for that of the Superintendent. It was without authority to do so (*Matter of Procaccino v Stewart*, 25 NY2d 301). The Superintendent is vested by the statute with broad power and responsibility to implement the Insurance Law (*Matter of New York Public Interest Research Group v New York State Dept. of Ins.*, 66 NY2d 444; *Ostrer v Schenck*, 41 NY2d 782). As these and other cases hold, a determination of the Superintendent is to be upheld by the courts unless it lacks a rational basis (*Matter of*

American Tr. Ins. Co. v Corcoran, 105 AD2d 30, *affd* 65 NY2d 828)." (*Matter of Schwartz v Corcoran*, 118 AD2d 355, 361.)

It hardly seems necessary to address the constitutional arguments advanced by respondent. The history of the efforts by Legislatures and Governors to solve this problem, the factual record before the Superintendent, the applicable legal standards for judging the constitutional claim, long-standing decisions of the Court of Appeals and Federal appellate courts, including the Supreme Court, that rejected similar constitutional attacks on legislation which States employ to regulate insurance under their police power within constitutional constraints, make such contentions nugatory. (*See*, dissent in *Medical Malpractice Ins. Assn. v Cuomo*, 138 AD2d 177, 187.)

As found by the Referee, the Regulation adopted by the Superintendent dealing with the primary rates for the 1985-1988 period had a rational basis and was not arbitrary or capricious. [*See*, 137 Misc 2d 785.]

APPENDIX D

Opinion of the Supreme Court of the State of New York, County of New York

SUPREME COURT OF THE STATE OF NEW YORK,
COUNTY OF NEW YORK

Decided October 9, 1987

IN THE MATTER OF MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Petitioner,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

APPEARANCES OF COUNSEL

Werner, Kennedy & French (T. Richard Kennedy and *Larry P. Schiffer* of counsel), for petitioner. *Robert Abrams, Attorney-General (Jane Breslin Jacobs* and *Frank J. Wenick* of counsel), for respondent.

Appendix D

OPINION OF THE COURT

MARTIN EVANS, J.

In this proceeding under CPLR article 78, petitioner seeks judgment annulling the determination of the respondent Superintendent of Insurance which established both primary and two levels of excess premium rates for physicians' and surgeons' professional liability insurance for two policy years: July 1, 1985 through June 30, 1986 and July 1, 1986 through June 30, 1987. By amendment of the petition, petitioner also seeks the same judgment with respect to the policy year July 1, 1987 through June 30, 1988.

Petitioner Medical Malpractice Insurance Association (MMIA) alleges that the determination made by respondent was arbitrary and capricious; that it was the result of abuse of discretion; that it was made in violation of lawful procedure; that it is in violation of the 5th and 14th Amendments of the US Constitution and that it violates sections 6 and 7 of article I of the NY Constitution.

Petitioner also seeks judgment compelling respondent to establish proper premium rates for those three policy years, in compliance with the Insurance Law.

Petitioner is a nonprofit unincorporated association, first established by the Legislature in 1975 to provide medical malpractice insurance. The members of petitioner at any one time are all the insurance companies which at that time underwrite personal injury liability insurance in the State of New York, and one of the conditions of their doing business in this State is that they are required to be members of MMIA. Presumably if they cease doing that type of business they need no longer be members of MMIA.

Those insurance companies which are members of MMIA are required to make up any deficit which may be incurred by MMIA as a result of its insurance operations.

The rate for the policy year 1984-1985 had been established by the Superintendent based on the findings and recommenda-

tions of Honorable Dominick L. Gabrielli, who had served as a Special Hearing Officer for that purpose. Thereafter, the Superintendent promulgated an amendment to regulation 101 (11 NYCRR part 70), which reduced the 1984-1985 rates by 15%.

A hearing on the rates to be established for 1985-1986 was held before Honorable Matthew J. Jasen who sat as a Special Deputy Superintendent. During the pendency of the hearing the Superintendent, on the basis of the evidence and of the experience up to that time, allowed an interim rate increase of 20% over the base rate. The determination of Judge Jasen was that the rates for the year in question before him should be increased for primary insurance by 86.7%, and for excess insurance by 30% and 20%, respectively, for the two layers of insurance, over the 1984-1985 base rate.

However, before the Superintendent acted upon Judge Jasen's recommendation, the Legislature, reacting to well-known problems in the malpractice insurance field, enacted Laws of 1986 (ch 266). In general, this was a legislative attempt to begin to resolve the problems that were apparent. Specifically, section 40 of that chapter provided a mechanism which allowed the Superintendent to set the rates for the three policy years of 1985-1988; and in the event the experience of those three years resulted in an actuarially projected deficit, provided for a premium surcharge not to exceed 8% on all policies which commenced in the policy year 1989 and to continue for an indeterminate number of years, to satisfy any projected deficiencies which would then be considered attributable to the rates which had been set for the policy years 1985-1988.

Section 40 also provides that the surcharges shall be deemed to be income earned for the purposes of section 2303 of the Insurance Law.

Acting ostensibly under the authority of this enactment, and using 1984-1985 as a base, the Superintendent determined that the premium increases for the periods in question should be as follows:

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	Primary Rate	Excess Rate	
		1st Layer	2nd Layer
1985-86	14%	30%	20%
1986-87	9%	35%	24%
1987-88	9%	40%	28%

The matter was referred, by agreement, to Honorable Samuel S. Silverman, to hear the evidence supporting the contentions of the parties and to report to the court.

It is clear from the evidence before the Referee, and he has reported, that the rates fixed by the Superintendent for both the primary and the two excess layers of insurance are entirely inadequate to meet the statutory standards which have been fixed by the Insurance Law. However, the Referee concluded that the determination of the Superintendent was proper, based upon the effect which he thought should be given to section 40.

I

(a)

There are two sets of statutory standards which are applicable.

The first is found in Insurance Law, article 23, § 2303, which provides that, "Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers."

The second standard is found in article 55, which, in section 5505 provides that, "(a) The rates * * * shall be subject to article twenty-three of this chapter, giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the superintendent may require."

To the extent that the rates are subject to article 23, one must look at section 2301, which sets forth the purposes of article 23.

In that connection, it should be noted that while section 2303 sets forth a statement as to what the rates shall *not be*, subdivision (b) of section 5505 provides affirmatively that the rates shall be "on an actuarially sound basis, be calculated to be self-supporting, be based on reasonable standards".

There are different purposes for these two sets of standards which otherwise would seem partially to overlap.

Article 23 applies to all types of insurance written by any insurer authorized to do business within the State; by section 2301 it can be seen that the purpose of article 23 is essentially to promote price competition and competitive behavior among insurers. The prohibition of "inadequate" rates under article 23 is, in general terms, designed to prevent unfair and discriminatory practices and also to maintain the availability and reliability of insurers.

(b)

This court does not agree with the contention of the Superintendent that the direction in section 40 (L 1986, ch 266) to the effect that the surcharge shall be deemed to be income for the purposes of section 2303 was intended to override the direction in section 5505 that the rates which were to be fixed by the Superintendent were to be actuarially sound, self-supporting, and based on reasonable standards.

While courts should give deference to an agency's practical construction of a statute over a period of time (*see, e.g., Town of Amherst v County of Erie*, 260 NY 361, 369-370), the construction proposed here is one of first impression, and is not entitled to absolute judicial deference, since the ultimate responsibility of interpreting the law rests with the court. (*See, Matter of Exxon Corp. v Board of Stds. & Appeals*, 128 AD2d 289, 296.)

While section 40 (L 1986, ch 266) was enacted to restrain and stabilize soaring medical malpractice insurance rates, this court does not conclude that the Legislature, to effectuate that result, intended to change the general rules set forth in the Insurance

Law. The legislative intent to reduce soaring malpractice rates (*see*, L 1986, ch 266, § 1) was to be effectuated by many other means, only one of which was to allow the Superintendent of Insurance to fix rates.

It would be impermissible for the Legislature to effectuate that purpose by requiring that the Superintendent act in such a way as to effectuate an unconstitutional result, which would be the case if the statute were to be read to require rates that did not allow a reasonable rate of return to the petitioner or to its members.

Article 55 refers solely to petitioner, which was created by that article. Under section 5505, the rates are required to be actuarially sound, self-supporting, and are to be based on reasonable standards.

The history of the adoption of the predecessor to article 23 is set forth in *Matter of Smith v Wikler* (10 AD2d 195). Its purpose was to satisfy the requirements of the McCarran-Ferguson Act (15 USC §§ 1011-1012) which imposed a moratorium on the application of Federal antitrust laws to the business of insurance, so long as the business of insurance was regulated by State law.

That purpose, now set forth in section 2301, was to provide for the promotion of price competition and competitive behavior; to provide rates that are responsive to market conditions; to improve the availability and reliability of insurance and to regulate competition among insurers. Rates for those purposes were not to be excessive or inadequate or unfairly discriminatory.

Section 2303, which sets the standards for rates under article 23, implements each of those purposes and to insure the availability and reliability of insurance, states that the rates shall not be detrimental to the solvency of insurers. For these purposes, the Superintendent may broadly include all income on all the insurer's investments of any kind and wherever located.

Thus, an insurer may not be permitted to set an unusually low rate, which might be destructive of competition, or which might lead to insolvency, unless it can be shown that the insurer

has sufficient investment income from all sources to be able to promulgate such a low rate.

The Superintendent has taken the position that despite the present insufficiency of the rates, he has legislative authorization to set them at that level by reason of the last sentence of section 40 (L 1986, ch 266), which, he claims, gives him the right to consider the surcharges to be imposed commencing in 1989 as a part of the rate. He claims that these surcharges, if imposed in 1989 and continued to be imposed on each future annual premium until approximately the year 2000, will be sufficient to make up the deficit for the years 1985-1988 which is presently foreseen as a result of his present rate determination.[1]

He bases this on his conclusion that the Legislature, in enacting Laws of 1986 (ch 266), intended that the rates for 1985-1988 period be inadequate, and that the burden of this intended inadequacy be passed on to a succeeding generation.

However, not only is there no clear language which would permit this interpretation, but an examination of section 40 leads to a contrary conclusion.

Specifically, after directing the Superintendent to establish rates for the 1985-1988 period, the Superintendent is directed to cause the insurers to establish segregated accounts for those years for premium payments, reserves and investment income attributable to that period, and to require periodic reports, "to monitor whether the accounts will be sufficient to meet incurred claims and expenses." (L 1986, ch 266, § 40.)

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1. The Referee found, and both sides appear to agree, that there was no rational basis for the Superintendent's decision in setting excess rates. The Referee concluded that the 8% future surcharge should be considered in setting those rates, but found that even with that surcharge, there was not even a prima facie showing that the excess rates were proper.

There was no showing as to how much of the 8% surcharge will be applied, *in futuro*, to the primary rates and how much to the excess rates, from which this court can only conclude that there was no basis for the optimistic conclusion by the Superintendent that the 8% surcharge will ultimately make up the 1985-1988 deficit.

This language expresses the legislative hope that the rates to be set would be sufficient, under the existing circumstances of general uncertainty in the malpractice insurance field. The language does not support the Superintendent's position that the Legislature intended that the rates be set so that the accounts would be insufficient for that three-year period.

The court reads section 40 to provide that if the rates proved to be inadequate, only then would the surcharge, if necessary, be imposed; and then only up to 8% of the then allowed premiums.

It is clear that the Superintendent was not to impose the full 8% surcharge, unless and until his monitoring of the accounts toward the end of the 1985-1988 period established a necessity for that action.

From all the evidence, it is apparent that the position of the actuaries for the Superintendent, upon whom he relied, was that the surcharge, beginning in 1989, was to be fixed at 8%; and their calculations of the 1985-1988 rates was based on their present determination that the 8% surcharge would be necessary.

Only if section 40 (L 1986, ch 266) were read to require that the Superintendent make the 8% surcharge determination at the present time, instead of waiting (as § 40 seems to require) for the periodic reports during the 1985-1988 period, might the position of the Superintendent be sustained.

(c)

He has not contended, nor was there any evidence adduced before the Referee, that even with the surcharge, there will be an adequate return to enable the members of petitioner to make any return on their compelled investment, at a reasonable profit, which they are entitled to do. (*See*, Insurance Law § 2304[a].) Indeed, if the Legislature had intended to prohibit a reasonable return on investment, there would be serious question as to the constitutionality of the Legislation. (*See*,

Prendergast v New York Tel. Co., 262 US 43;[2] *Brooks-Scanlon Co. v Railroad Commn.*, 251 US 396, 399.)[3]

That MMIA was created as a nonprofit corporation and that membership in MMIA by the member insurers is a condition of their doing business in this State does not give the State, acting through the Superintendent's rate-making powers, the power to require them to invest in or to maintain a losing business for the benefit of others.

(d)

None of the foregoing considers the question of insolvency as a result of the income and expenses up to the 1985-1986 policy year. While the petitioner was not insolvent in the equity sense (that is, it is able to pay its present debts as they mature) the statutory test set forth in section 1309(a) of the Insurance Law is somewhat different. Respondent has conceded, during argument, that the definition in section 1309 is applicable.

While the statute does use the words "unable to pay its outstanding lawful obligations as they mature in the regular course of business", the statutory tests for this are set forth in the next following phrase: "as shown by an excess of required reserves and other liabilities over admitted assets, or by its not having sufficient assets to reinsure all outstanding risks * * * after paying all accrued claims owed". (Insurance Law § 1309[a].)

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2. "They [the temporary rates] were final legislative acts as to the period during which they should remain in effect pending the final determination; and if the rates prescribed were confiscatory the Company would be deprived of a reasonable return upon its property during such period, without remedy, unless their enforcement should be enjoined. Upon a showing that such rates were confiscatory the Company was entitled to have their enforcement enjoined pending the continuance and completion of the rate-making process." (*Prendergast v New York Tel. Co.*, 262 US 43, 49.)

3. "A carrier cannot be compelled to carry on even a branch of business at a loss, much less the whole business of carriage * * * The plaintiff may be making money from its sawmill and lumber business but it no more can be compelled to spend that than it can be compelled to spend any other money to maintain a railroad for the benefit of others who do not care to pay for it." (*Brooks-Scanlon Co. v Railroad Commn.*, 251 US 396, 399.)

The evidence is undisputed that by this test MMIA is insolvent.

In *Stewart v Citizens Cas. Co.* (61 Misc 2d 809, *revd* 34 AD2d 525, *affd* 27 NY2d 685, *cert denied* 401 US 910) insolvency was defined as an excess of reserves over admitted assets. It is clear that the test looks to the future maturation of present and potential claims, against the presently admitted assets.

The Referee found that the proposed rates would not *impermissibly* impair the solvency of MMIA; it seems clear from the evidence that petitioner's solvency is, and will continue to be impaired. If it was the legislative intent to so modify not only section 5505 of the Insurance Law, but long-standing general principles of the requirement of solvency of insurance companies, it is not apparent from the statute.

II

It is difficult for the court, as it was for the Referee, to determine what the basis for the determination of the Superintendent was. The Superintendent's actuaries, who presented him with their conclusions based upon various "scenarios" of rate structures were likewise unable to determine the basis for his action. The scenarios themselves were, as described by one of this actuaries, "not an analysis so much as it is one scenario", and depends upon future results which themselves rest on a speculative foundation with no basis in past experience. This is not an actuarial basis.

There was, therefore, no proper actuarial basis, or other basis before the Superintendent which could serve as a foundation for his determination.

CONCLUSION

Based on the foregoing analysis, the court concludes that the report of the Referee should not be accepted, and that the determination of the Superintendent should be set aside.

APPENDIX E

The Constitution of the United States

Amendment V

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Amendment XIV

§ 1 All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

APPENDIX F

1986 Laws of New York, Chapter 266

§ 40. The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-eight. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July first, nineteen hundred eighty-nine, the superintendent shall impose a surcharge on premiums to satisfy any actuarially projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the approved adequate rate and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. On and after July first, nineteen hundred eighty-nine, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July first, nineteen hundred eighty-five through June thirtieth, nineteen hundred eighty-eight policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods. In the event any insurer that provided coverage during such policy periods is in liquidation, the

property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law.

APPENDIX G

Insurance Department of the State of New York
Tenth Amendment to Regulation No. 101
(11 NYCRR 70)

MEDICAL MALPRACTICE INSURANCE RATE MODIFICATIONS, PROVISIONAL RATES, REQUIRED POLICY PROVISIONS, AND AVAILABILITY OF COVERAGE

I, JAMES P. CORCORAN, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301, 1103, 1113(a)(13) and (14), 3437, 5502, 5504, 6302, 6303, and Article 23 of the Insurance Law, and Chapter 266 of the Laws of 1986, do hereby promulgate, on an emergency basis, the following amendment to Part 70 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Tenth Amendment to Insurance Department Regulation Number 101), to take effect immediately upon filing with the Secretary of State, to read as follows: Section 70.1 is hereby amended by adding a new subdivision (l) as follows:

(l) Purchasing group means any group formed pursuant to the federal "Liability Risk Retention Act of 1986" ("LRRA") (15 U.S.C. 3901 et. seg.) and:

(1) has as one of its purposes the purchase of liability insurance on a group basis;

(2) purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (3) this subdivision;

(3) is composed of members whose business or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(4) is domiciled in any state.

Section 70.8 is hereby amended as follows:

Section 70.8. Physicians Medical Malpractice Liability Insurance Rates for Claims-made and Occurrence Primary and Excess Policies and Claims-made Tail Coverage

(a) Pending enactment of Chapter 266 of the Laws of 1986, which was signed into law on July 8, 1986, all physicians medical malpractice liability insurers were directed by the Fifth Amendment to Part 70 (Section 70.8 repealed by [this] *the Eighth* amendment *of this part*) that the rates for the policy period commencing July 1, 1986, and ending June 30, 1987 would continue to be, on a provisional basis, the rates last approved by the Department for said insurers. All insurers that issued policies of medical malpractice liability insurance, as defined in Section 70.1(a) of this Part, and all insurers with special licenses under Section 6302 of the Insurance Law that issued policies including such coverage, were directed to furnish their insureds with the following endorsement in connection with all such policies in effect on and after July 1, 1986:

> "THE PREMIUMS ON THIS POLICY FOR THE PERIOD OF COVERAGE COMMENCING ON OR AFTER JULY 1, 1986 THROUGH JUNE 30, 1987 ARE PROVISIONAL AND ARE SUBJECT TO UPWARD OR DOWNWARD ADJUSTMENT. INSUREDS MAY BE REQUIRED TO PAY AN AMENDED PREMIUM RETROACTIVE TO JULY 1, 1986, OR THE ANNIVERSARY DATE OF THE POLICY, WHICHEVER IS LATER OR BE ENTITLED TO A CREDIT IF IT IS DETERMINED THAT A DOWNWARD ADJUSTMENT IS NECESSARY IN ORDER TO MEET STATUTORY RATING STANDARDS."

(b) Pursuant to Section 40 of Chapter 266 of the Laws of 1986, the Superintendent was directed to establish rates for pol-

icies providing coverage for physicians medical malpractice liability insurance for the periods commencing July 1, 1985 and ending June 30, 1988. The rates established herein for policies issued or renewed during the year July 1, 1985 through June 30, 1986 supersede the provisional rates mandated by Section 70.5 for primary coverage and by Section 70.6 for excess coverage, and interim rate increases, if any, approved by the Superintendent for such policy year, and the rates established by prior amendment of this Section, where inconsistent with this amendment. The rates established herein for policies issued or renewed during the year July 1, 1986 through June 30, 1987 supersede the rates established by prior amendment of this Section, where inconsistent with this amendment. Insurers shall charge a rate for physicians medical malpractice liability insurance only as established by the Superintendent.

(c) *Base year occurrence rates:*

(1) For the purposes of this Part, the base year occurrence rate shall be the occurrence rate approved for the insurer by the Superintendent for policies issued or renewed during the year July 1, 1984 through June 30, 1985, as reduced by the fifteen percent downward modification mandated by Section 70.5(c)(1).

(2) For any insurer that had no base year occurrence rate as provided in paragraph (1) of this subdivision, but had a claims-made rate approved, the base year occurrence rate shall be the third year claims-made rate approved by the Superintendent, as reduced by the fifteen percent downward modification mandated by Section 70.5(c)(1), multiplied by 1.158.

(3) For any insurer that utilized a rate which has not been approved by the Superintendent, and for any insurer that has not previously written policies subject to this Part, the base year occurrence rate shall be the approved rate of another insurer, that is most appropriate for that insurer, together with any modification which can be adequately supported. Such rate shall not be used until established by the Superintendent.

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(d) *Rating plans*

(1) For any insurer that utililized a rating plan which has not been approved by the Superintendent, and for any insurer that has not previously written policies subject to this Part, the rating plan shall be the approved rating plan of another insurer that is most appropriate for that insurer, together with any modification which can be adequately supported. Such plan may not be used until it is approved by the Superintendent.

(2) For any insurer that currently has an approved rating plan, such insurer shall continue to use such rating plan, except that the insurer may adopt the approved rating plan of another insurer that is most appropriate for that insurer. In either case no modification shall be permitted unless it can be adequately supported and results in no overall rate level change for the insurer. No modification or alternate rating plan may be adopted for policies issued prior to July 1, 1986. Any modified or alternate rating plan may not be used until it is approved by the Superintendent.

(e) *Occurrence primary and excess coverage rates*

(1) Rates for occurrence policies issued or renewed during the year July 1, 1985 through June 30, 1986:

(i) For primary coverage, up to $1 million/$3 million, the rate shall be 14% greater than the base year occurrence rate;

(ii) For a first excess layer providing $1 million/$3million of excess coverage above $1 million/$3 million primary coverage, the rate shall be 30 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph:

(iii) For a second excess layer providing $1 million/$3 million of excess coverage above the underlying primary coverage and first layer of excess coverage, described in subparagraph (ii) of this paragraph, the rate shall be 20 percent of the $1 million/

$3 million rate for primary coverage established in subparagraph (i) of this paragraph:

(2) Rates for occurrence policies issued or renewed during the year July 1, 1986 through June 30, 1987:

(i) For primary coverage, up to $1 million/$3 million, the rate shall be 9 percent greater than that established pursuant to paragraph (1)(i) of this subdivision;

(ii) For a first excess layer providing $1 million/$3million of excess coverage above $1 million/$3 million primary coverage, the rate shall be 35 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph;

(iii) For a second excess layer providing $1 million/$3 million of excess coverage above the underlying primary coverage and first layer of excess coverage, described in subparagraph (ii) of this paragraph, the rate shall be 24 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph.

(3) Rates for occurrence policies issued or renewed during the year July 1, 1987 through June 30, 1988:

(i) For primary coverage, up to $1 million/$3 million, the rate shall be 9 percent greater than that established pursuant to paragraph (2)(i) of this subdivision;

(ii) For a first excess layer providing $1 million/$3 million of excess coverage above $1 million/$3 million primary coverage, the rate shall be 40 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph;

(iii) For a second excess layer providing $1 million/$3 million of excess coverage above the underlying primary coverage and first layer of excess coverage, described in subparagraph (ii) of this paragraph, the rate shall be 28 percent of the $1 million/

$3 million rate for primary coverage established in subparagraph (i) of this paragraph.

(4) The rates for the excess layers apply to policies purchased directly by physicians and to policies purchased by general hospitals on behalf of their eligible physicians, as required by Section 19 of Chapter 294 of the Laws of 1985 and by Section 18 of Chapter 266 of the Laws of 1986.

[(4)]*(5)*. The rates for occurrence excess layer policies providing coverage other than as specifically established herein shall be established by the Superintendent after a review of proposed rates and supporting documentation to be submitted by each insurer writing such coverage, in accordance with subdivision (j)(3) herein. The Superintendent shall consider such submissions, as well as any other relevant factors, and will thereafter establish a rate for each such excess layer.

(f) Claims-made primary and excess coverage rates

(1) Claims-made primary coverage rates

The claims-made rate for a particular primary coverage policy shall be the corresponding occurrence rate multiplied by the appropriate claims-made factor, as follows:

Year in Claims-Made Program	*Claims-made Factor*
First:	31%
Second:	64
Third:	85
Fourth:	94
Fifth:	99
Sixth:	*102*

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(2) Optional Extended Reporting Period (Tail) Primary Coverage Rates

(i) The rate for optional tail coverage that is required to be offered for a particular claims-made primary coverage policy shall be the corresponding occurrence rate multiplied by the appropriate tail factor, as follows:

Number of years completed in Claims-Made Program	*Tail Factor*
One:	74.8%
Two:	122.1
Three:	146.4
Four:	162.4
Five:	173.3
Sixth:	*181.0*

(ii) For a policy terminated on a date other than the policy anniversary date, the tail factor shall be obtained by interpolating, on a daily basis, between the tail factors applicable to the last and next policy anniversaries.

(iii) For any policy that was written at a reduced rate because the insured was eligible for a new doctor discount, the tail premium shall be reduced by a percentage equal to the percentage that the current year's rate (exclusive of any surplus contributions) was reduced as a result of such new doctor discount.

(3) Rates for claims-made and tail excess coverage policies purchased by hospitals

The aggregate rate for a claims-made excess coverage policy and its simultaneously issued tail (as mandated by subdivision (g) herein) purchased by a general hospital on behalf of a physician, shall be equal to the corresponding occurrence excess coverage rate.

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(4) Rates for claims-made and tail excess coverage policies purchased by physicians directly

The rates for the claims-made and tail first and second excess layers required to be offered when purchased directly by a physician, and the rates for any other claims-made and tail excess layer other than as specified herein, shall be established by the Superintendent after a review of proposed rates and supporting documents to be submitted by each insurer writing, or required to write, such coverage, in accordance with subdivision (j)(3) herein. The Superintendent shall consider such submissions, as well as any other relevant factors, and will thereafter establish a rate for each such excess layer.

(g) Excess Coverage—Types of Policies; Required Tail

(1) Pursuant to Section 19 of Chapter 294 of the Laws of 1985, and as established in Section 70.(7)(c), excess coverage policies providing $1 million/$3 million of excess coverage above $1 million/$3 million primary coverage, purchased by general hospitals on behalf of physicians, afforded such coverage for "occurrences" between July 1, 1985 through June 30, 1986 and were issued on an "occurrence" basis.

(2) Pursuant to Section 18 of Chapter 266 of the Laws of 1986, excess coverage policies providing $1 million/$3 million of excess coverage above $1 million/$3 million primary coverage, purchased by general hospitals on behalf of physicians, shall provide such coverage for "occurrences" between July 1, 1986 and June 30, 1987. Accordingly, all physicians medical malpractice liability insurers which issue such an excess policy on a claims-made basis shall simultaneously issue full tail coverage.

(3) Except where required to be issued on a claims-made basis pursuant to Section 5504(f), excess coverage policies issued or renewed or and after July 1, 1986 shall provide coverage on either an occurrence or claims-made basis, subject to paragraph (2) of this subdivision, provided that:

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(i) An excess coverage policy shall be renewed on the same basis (occurrence or claims-made) as it was previously issued, except that the insured may choose to substitute claims-made coverage for occurrence coverage.

(ii) If the insured so requests, an excess coverage policy issued by the same insurer that issued the underlying primary coverage shall be issued with the same type of coverage (occurrence or claims-made) as the primary coverage.

(4) The provisions of Sections 70.7(b)(2) and (d) continue to be applicable to all medical malpractice liability insurers.

(h) Segregated accounts

Physicians medical malpractice insurers shall establish segregated accounts for premiums, reserves, and investment income attributable to such policy year periods contained in subdivision (b) hereof, and are further required to report to the Insurance Department on a quarterly basis regarding claims and expenses attributable to such periods.

(i) Required filings-primary coverage

(1) All physicians medical malpractice liability insurers were required to file by August 1, 1986 amended rate manual pages with the Superintendent in accordance with the primary coverage rates established by prior amendments of this Part. Any such insurer not previously issuing a policy on a claims-made form was required to file such form for approval at the same time.

(2) [In accordance with this amendment, all] *All* such insurers are required to file by December 31, 1986 amended rate manual pages with the Superintendent in accordance with the primary coverage rates established [herein] *by the eighth amendment to this Part.*

(3) All such insurers are required to file by July 15, 1987 amended rate manual pages with the Superintendent in accord-

ance with the primary coverage rates established by the tenth amendment to this Part.

(j) Required filings-excess coverage

(1) All physicians medical malpractice liability insurers were required to file by August 22, 1986 amended rate manual pages with the Superintendent in accordance with the excess coverage rates established by prior amendments of this Part.

(2)(i) All such insurers are required to file by December 31, 1986 amended rate manual pages with the Superintendent in accordance with the excess coverage rates specifically established *[*herein*]* *by the eighth amendment to this Part.*

(ii) All such insurers are required to file by July 15, 1987 amended rate manual pages with the Superintendent in accordance with the excess coverage rates specifically established by the tenth amendment to this Part.

(3) Insurers writing, or required to write excess layers other than for which rates are specifically established herein shall file, by December 31, 1986, proposed rates with supporting documentation. *For the policy year 1987-1988, such insurers shall file by July 15, 1987 proposed rates with supporting documentation.*

(k) Rate Service organization

(1) A physicians medical malpractice liability insurance rate filed by a rate service organization on behalf of its members and subscribers shall be established in accordance with this Section. Any such organization shall make the appropriate rate filing required by subdivisions (i) and (j) of this section by December 31, 1986. *For the policy year 1987-1988, such organization shall make the appropriate rate filing by July 15, 1987.*

(2) A member or subscriber of a rate service organization may adopt the established rates and approved rating plan filed by the organization if said member or subscriber notifies the

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Department by December 31, 1986 and the Department determines that such filing is not inappropriate. *For the policy year 1987-1988, the member or subscriber shall notify the Department by July 15, 1987 that it is adopting such rates.*

(l) Purchasing groups

The rates and rating plan for medical malpractice liability insurance issued to a purchasing group and its members shall be established in accordance with the provisions of this part, except that, where the insurer and the purchasing group has complied with all applicable provisions of the LRRA, if an insurer submits rates or a rating plan affording advantages, based on the purchasing group's loss and expense experience, not afforded to other persons, the Superintendent shall review such submission, and thereafter establish rates or a rating plan, as appropriate, reflecting such advantages. Any such insurer shall file by July 15, 1987 proposed rates adequately supported.

m) Required filing-rating plans

(1) All physicians medical malpractice liability insurers shall file with the Superintendent by August 15, 1987 adequate support for their rating plans (as defined in this Part, but excluding the merit rating plan). Such insurers shall include actuarial data and other relevant considerations.

(2) Any insurer who has adopted the rating plan of another insurer, pursuant to subdivision (d) of this section may instead submit to the Superintendent a statement to that effect. Such statement will be deemed to be compliance with paragraph (1) of this subdivision.